REFERRAL TO NEW DIRECTIONS COUNSELING SERVICES, PLLC

Today's Date: _____

Patient's Name: _____ Patient's DOB: _____
Legal Guardian's Name & Phone: _____
Payer Source: _____Medicaid _____NC Health Choice _____Private Insurance _____Self Pay
Insurance Company: _____ Phone: _____
Policy ID: _____ Group Number: _____
Policy Holder's Name: _____ Policy Holder's DOB: _____

This patient is currently receiving medical care services at our practice and is in need of a Behavioral Health Assessment from you/your agency
Therapy _____ Psychological Evaluation _____

Practice Name & Referring Physician: _____

Address:_____

Phone: _____ Fax: _____ Email:_____

***Carolina Access Referral NPI # (if applicable)** _____

Referral Request

Specific concerns/requests/recommendations:

The following patient information is attached:

- ☐ Medical Diagnosis(es)
- ☐ Most Recent History and Physical
- ☐ Current Medication List
- ☐ Recent Lab work
- ☐ Insurance Card (**PLEASE ATTACH INSURANCE CARDS FRONT AND BACK)**
- ☐ Other _____

Signature: _____
(Physician/Physician Assistant/Nurse Practitioner) *Updated 10/1/14*

Hickory – 201 Government Ave SW Suite 305, Hickory, NC 28602 828-267-1740 Fax 828-267-1746
Lenoir – 315 Wilkesboro Blvd NE Suite 1A, Lenoir, NC 28645 828-754-6087 Fax 828-754-1344