Counseling Plus, LLC
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Lexington, SC 29072
803-727-3882
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Referral Form

Client name:_____

Policy Holder name (and relationship if not the client):_____

Policy Holder date of birth:_____

Insurance Type:_____

Policy number:_____

Phone number:_____

Email:_____

Address:_____

_____

Date of birth of client (if not policy holder):_____

Reason for counseling:_____
_____
_____

Referring physician/agency/office: _____

Contact Person: _____

Preferred Clinician:_____

For Office Use Only:

Clinician: _____

Appointment Date and Time: _____