2931 Breezewood Avenue Suite 200 Fayetteville, NC 28303
Phone:910-748-0833 Fax:910-827-6592

Referral for Services

Section I: Referral Source Demographics

Referral Source: ______________________________ **Date**: ______________

Referral Source Phone Number: ______________________

Referral Source Email Address: ______________________________________

Section II: Service Request

Check all Desired Services: ☐Emotional and Behavioral Psychotherapy ☐Trauma-Focused-CBT ☐Psychosexual Evaluation ☐Trauma Assessment ☐CCA/Mental Health Evaluation ☐Psychosexual/Sex Offender Treatment ☐ Eating Disorder Treatment ☐ Psychological Evaluation ☐ Autism Treatment

☐ Medication Management ☐ Addictions Evaluation ☐ Addictions Treatment ☐ Autism Evaluation

☐ Disability Benefits Questionnaire (DBQ)-Veterans only ☐ Parenting Evaluation

☐ Other:____

Section III: Patient Demographics

Patient Name: ____

DOB: __________________ **Age**: ________________ **Gender:** ______________

Race/Ethnicity: ____

SSN#: ______________________ **Primary Language:** ______________________

Insurance Carrier: _______________ **Insurance Policy Number:** ______________________

Address: ______________________________________ **Phone Number:** ______________

Section V: Reason for Referral

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