ASHWOOD COUNSELING

Ashwood Counseling LLC
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Simpsonville, SC 29681
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Referrals@ashwoodcounseling.com
www.ashwoodcounseling.com

Mental Health Referral Form

Date of referral: _____

Referral Source

Referring Agency: _____

Physician's Name (If applicable): _____

Referral Contact: _____

Phone: _____ Fax: _____

Patient's Information

Patient's Full Name: _____ Patient's Date of Birth: _____

Parents/Guardian Name (if under 18): _____

Street Address: _____ City/State: _____

Phone #1: _____ Phone #2: _____

Email: _____

Insurance Provider(s): _____

Reason for Referral: _____

_____

_____

For Office Use Only

1st attempt: _____ 2nd attempt: _____

3rd attempt: _____ Intake date: _____

Notes/Comments: _____

_____

Please submit completed referrals to Referrals@ashwoodcounseling.com (HIPPA compliant) or fax to 844-300-6266 (HIPPA complaint).