REFERRAL FORM

Client's Name: _____ **Date of Referral:** _____

Insurance ID Number: _____ **Address:** _____

Birthdate: _____ _____

Telephone Number: _____

Referral To:

Fitzpatrick and Watson Counseling, LLC
600 Interstate Park Dr., Suite 609
Montgomery, AL 36109
Phone: (334) 676-3520/Fax: (334) 676-3521

Referred By:

_____

_____

Reason for Referral:

_____

_____

_____

Authorization: I, _____ [Client's name], give my permission to _____ [Service Provider's Name] to release this information to _____ [Care Coordination Provider's Name]. The information is to be used to assist me in monitoring and coordinating my health care and social service needs.

Signature of client/parent or guardian: _____

Date: _____

Service Provider's Reply (summery of findings, diagnosis, recommendations, comments, as appropriate)

Signature: _____ **Date:** _____