



BONITA HUTCHINSON AND ASSOCIATES, PLLC

Referral Form for Mental Health, Alcohol, Drugs & Behavioral Health

The consumer below is seeking treatment and services

Referral Source

Name : _____ Relation to Client: _____ Your Address: _____

Your Phone #: _____

Client's Primary Physician: _____ Doctor's Phone # _____

Client Information:

NAME: _____ GENDER: _____ D.O.B.: _____

ADDRESS: _____ PHONE: _____

LEGAL GUARDIAN: _____ LEGAL GUARDIAN PHONE: _____

METHOD OF PAYMENT: SELF PAY Blue Cross Blue Shield of NC Insurance Group # _____

AETNA ID# _____ Cigna Insurance ID# _____

Current or Past Treatment, Psychiatric Hospitalization, Detox or Counseling :

WHERE: _____ WHEN: _____

WHY : _____

Reason for this Referral: Mental Health Substance Abuse DOT – SAP Evaluation GROUP

Symptoms Reported/ Needs:

____ Depression ____ Hallucinations (*Visual/Auditory/Olfactory*) ____ Racing Thoughts ____ Anxiety

Known Mental Illness or Addiction Diagnosis: _____

5200 Park Road, Charlotte NC 28209

Please email form to: Info@BhutchinsonCounseling.com OR call to schedule an appointment at 980-533-5839

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