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