Psychological Solutions of Lake Norman, PLLC

New Client Referral Form

Fax this completed referral form along with recent clinic notes to 704-663-2554

Date: _____

1. Client Information

Client name: _____ DOB: _____

Parents name, if under 18 years old: _____
Patient Preferred Language: _____

If other than biological parents, who has legal custody: _____

☐ **Was informed that we must have a copy of the custody agreement before the child is seen.**

Client address: _____

City: _____ State: _____ Zip: _____
Phone: (H) _____ (C) _____
Email address: _____

2. Referral Information:

Referral source: _____ Practice name: _____
(Example: Dr Dixon) (Example: Catawba Pediatrics)

Phone #:_____ Fax #: _____

Please check all that apply:

☐ ADHD (4-21) ☐ Autism Spectrum (4-17) ☐ Behavior Disorder ☐ Learning Concerns
☐ Brain Injury ☐ Epilepsy ☐ Neurodevelopemental Condition ☐ Intellectual Disabilty
☐ Depression / Anxiety ☐ Gifted / Early Kindergarten

Please briefly describe the reason for the referral:

_____
_____
_____
_____

☐ **If client is a child, parent DO NOT need to bring them to the first appointment.**

☐ **If referred for Psych-Ed testing: Informed to bring copies of ANY PRIOR testing to initial appointment.**

☐ **If referred for Bariatric testing: MUST BRING LAST 2 YEARS MEDICAL RECORDS.**
*****This includes all hospitals and all private practice providers*****

3. Insurance Information: (Please include a clear copy of the front and back of the card, if you have it)

Primary Insurance

Plan Name:_____
Member ID:_____
Group #: _____
Policy Holder: _____
Policy Holder DOB:_____

Secondary Insurance

Plan Name: _____
Member ID: _____
Group #: _____
Policy Holder:_____
Policy Holder DOB: _____