Psychological Solutions of Lake Norman, PLLC

New Client Referral Form

Fax this <u>completed</u> referral form along with recent clinic notes to <u>704-663-2554</u>

Client Information Client name:			Date:	
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: City: State: City: State: City: Phone: (C) Email address: 2. Referral Information: Referral source: (Example: Dr Dixon) Phone #: Please check all that apply: AbHo (4-21) Aurism Spectrum (4-17) Behavior Disorder Neurodevelopemental Condition Intellectual Disability 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 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: Member ID: Group #: Policy Holder: Pale Mames Head A and A and A and A seen and A	1. Client Informati	<u>ion</u>		
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