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: ____

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 Family Practice)

Phone: ______________________________ Fax:________________________

Please briefly describe the reason for the referral: ____

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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)

Insurance company: ____

Subscriber's name: ______________________________________ Relationship: _________________

Subscriber's DOB: ___________________ Member ID number: ________________________________

Group number: ________________________