R.E.A.L. Counseling, LLC
Referral Form

(Aleigh Everhart, LPCS, LCMHC – Telehealth)

Please complete this referral form and send back to us via fax or email!
We will typically follow up with client within 24 hours.

FAX: 843.273.0075

EMAIL: admin@realcounselingllc.com

Date of referral: _____

Client Name: _____

If minor child, parent/guardian name: _____

Client Contact Info: _____

Age: _____ Date of Birth: _____ Sex: _____

PLEASE CHECK CLIENT CONTACT PREFERENCE:

☐ Client prefers to be contacted via phone to schedule Appointment.

☐ Appointment has been scheduled online (date) _____.
Client will complete required documentation PRIOR to appointment.

This client has been referred by: _____
(Office/Facility)

Provider Name: _____Your Phone Number:_____
(MD name)

Your fax number: _____Contact name: _____

Brief description of reason for counseling referral: _____
_____
_____

~Thank you for the referral ~