Family Psychological Center, P.A.
Charles Nichols, Psy.D.
623 North Walnut Street · Harrison, AR 72601
Harrison, AR 72601
Phone: (870) 743-6225 · Fax: (870) 743-6006
fpcharrison.com (Additional forms available at this site)

REFERRAL FORM
OUTPATIENT PSYCHOLOGY

REFERRAL DATE: _____-_____-_____

NOTE: PLEASE COMPLETE ALL SECTIONS OF THIS REFERRAL FORM AND FAX TO (870) 743-6006.

Is your patient (or parent if a minor) aware of this referral? ☐ Yes ☐ No

PATIENT INFORMATION

Name of Client: _____ (Last / First / Middle)

Date of Birth: _____-_____-_____ (Month / Day / Year) Sex: ☐ Male ☐ Female SSN: _____

Home Address: _____ (Street / City / State / Zip)

Home Phone: _____ Work Phone: _____ Cell Phone: _____

PARENT(S) OR GUARDIAN(S) - (IF MINOR PATIENT)

Mother/Guardian: _____ (Last / First / Middle)

Home Address: _____ (Street / City / State / Zip)

Work Phone: _____ Cell Phone: _____ Email: _____

Father/Guardian: _____ (Last / First / Middle)

Home Address: _____ (Street / City / State / Zip)

Work Phone: _____ Cell Phone: _____ Email: _____

PRESENTING PROBLEM AND SERVICES REQUESTED

Diagnoses: _____

Requested Services (check all that apply):

☐ Psychological Testing ☐ Diagnostic Clarification ☐ Pre-surgical Evaluation
☐ Individual Psychotherapy ☐ Family Therapy ☐ Couples Therapy
☐ Learning Assessment ☐ Behavioral Modification ☐ Parenting Skills Training
☐ Other: _____

REFERRING PROVIDER

Name: _____ Agency/Practice: _____

UPIN: _____ NPI: _____

Office Phone: _____ Office Fax: _____ Contact Name: _____

Thank you for your confidence in our clinical psychology services! Fax to (870) 743-6006.

OFFICE USE ONLY

PT NOTIFIED: ____-_____-_____ APPT: _____/_____-_____-____ MD NOTIFIED: _____-_____-_____ INITIALS: _____