1610-A Graves Mill Road
Lynchburg, VA 24502
Phone: (434) 205-8049
Fax: (833) 402-0997

Provider Referral Form

Referring To

Specialty:	**Phone:**	**Fax:**
Practice Name & Address:		

Please Schedule (select all that apply):

- ☐ Urgent ____________________
- ☐ Routine Appointment with Specific Counselor listed: ____________________
- ☐ First Available with any Counselor

Referring Provider's Name:	**Phone:**	**Fax:**

Type of Referral

- ☐ Evaluation consultation with treatment recommendations
- ☐ Evaluation consultation with assumed care for medication management
- ☐ Evaluation consultation with treatment recommendations and shared care
- ☐ Specialist to Specialist*–Secondary Referral
  *Send copy of this referral to patient's primary care physician.
- ☐ Other (designate) ____________________

Patient Information

Patient Full Legal Name:		DOB
If patient is under 18 years old – Parent Contact Name:		
Preferred Phone:	Best time to call:	
Special Patient Considerations:		
Patient Insurance Information:		
	Phone:	Fax:

General Information

Reason for Referral (*Clinical Question*):

Comments:

Patient aware of reason for referral? ☐ Yes ☐ No: Explain

Provider Referral Confirmation

Referral

Referral Accepted? ☐ Yes ☐ No: Explain

Appointment Scheduled with:	**Date & Time:**

☐ Patient refused scheduling ☐ Patient prefers to contact specialist to schedule at a later date

Request for additional supporting clinical information (please detail):	
Person completing confirmation:	**Date of Confirmation:**