REFERRAL/SCREENING FORM

Please complete and fax referral form to: ____________________

Providers can also complete our online referral form at www.qc-counseling.com

CLIENT INFORMATION

Referral Date: ____

Client Surname: ______________________________First Name: _________________________________
Age: ____________ DOB:_____________________ (MM/DD/YYYY) Gender: ☐ Male ☐ Female

Address: ____

____

____

Client Phone #: ____

GUARDIAN INFORMATION (please list all parents/guardians):

Name: ___________________________ E-Mail: ____________________ Phone: _______________

Name: ___________________________ E-Mail: ____________________ Phone: _______________

Child Resides with: ____

Are there legal circumstances that prevent us from speaking to both parents ☐ Yes ☐ No

If yes, which parent should we contact: ____

Additional Contact Person other than Parent (if applicable):____________________________________

Relationship:_____________________________ Contact Person Phone:____________________________

REFERRING PROVIDER INFORMATION:

Referring Provider Name: ____

Referring Provider Agency: ____

Address: ____

____

5950 Fairview Rd. Ste 740. Charlotte, NC 28210
(704) 457-7001

____

Phone: __________________________________ Fax: __________________________________

REFERRAL INFORMATION: Has this patient seen any of the following in the last month:

Pediatrician ☐ Yes ☐ No If yes, Name/Contact/Next Appointment

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Psychiatrist ☐ Yes ☐ No If yes, Name/Contact/Next Appointment

____

Therapist or other counselor ☐ Yes ☐ No If yes, Name/Contact/Next Appointment

____

Are there any other relevant professionals involved? ☐ Yes ☐ No If yes, Name/Contact/Next Appointment

____

REASON FOR REFERRAL:

☐ Individual Therapy ☐ Group therapy ☐ EMDR

Diagnosis: ____

PLEASE PROVIDE DETAILS ON THE SEVERITY OF THE PSYCHIATRIC CONCERNS AND THE EFFECT ON DAILY FUNCTIONING (Please attach copies of relevant reports).

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RELEVANT MEDICAL HISTORY & CURRENT MEDICATIONS (including dosage and prescribing physician if different than referral source):

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