COASTAL
BEHAVIORAL
SCIENCES

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New Patient Referral Form

Fax to 910-254-4819

*** *A copy of <u>both</u> sides of the patient's insurance card <u>must</u> accompany this form.* ***

Patient Name: _____

Patient DOB: ____/____/_____ Age*:_____ Gender: M F

Address: _____

City: _____ State: _____ Zip Code: _____

Best phone number to reach patient: (_____) _____-_____

Alternate phone number: (_____) _____-_____

* If the patient is a minor (less than 18 years old), the following is required:

Legal guardian's name: _____

Legal guardian's address: Same or _____

_____

Legal guardian's phone number: (_____) _____-_____

Relationship to patient:_____

Name of referring provider: _____

Address of referring provider: _____

Phone: (_____) _____-_____ Fax: (____) _____-_____

* ***Please fax this form along with copies of both sides of patient's insurance card to 910-254-4819. Incompletion or failure to attach both sides of insurance card may result in delayed scheduling. We will contact your patient about the referral and appointment request as soon as possible. The providers at Coastal Behavioral Sciences thank you greatly for this referral!*** *

REASON FOR REFERRAL (PLEASE BE SPECIFIC)

- o Psychiatric Assessment (medication evaluation and/or management)
- o Psychological Assessment (testing for ADHD, LD, Mood Disorders, Autism, etc.)
- o Neuropsychological Assessment (testing for memory, dementia, TBI, stroke)
- o Psychotherapy (therapy for depression/anxiety, ADHD, PTSD, stress management, family/marital issues, etc.)
- o Other (explain): _____