West Counseling, PLLC

Please Fax to admissions/intake at 704-461-4334

Referral Sheet

NAME _____ AGE ___ DATE OF BIRTH _____

ADDRESS _____
Street City State Zip

HOME PH _____ CELL PH _____

EMAIL: _____

Insurance Info:

Name of insured: _____ Policy/ID #:_____ Group #_____

Phone number:_____ Address:_____

Policy holder Name:_____ DOB:_____ Employer:_____

Co Pay:_____ Co Insurance:_____ Deductible_____

Secondary Insurance info:

Name of insured: _____ Policy/ID #:_____ Group #_____

Phone number:_____ Address:_____

Policy holder Name:_____ DOB:_____ Employer:_____

Co Pay:_____ Co Insurance:_____ Deductible_____

(If consumer is a child) PARENT/LEGAL GUARDIAN_____ Ph# _____

PARENT/LEGAL GUARDIAN_____ Ph# _____

Primary Care Physician office: _____ Ph# _____

Fax#: _____

Referring Provider/NPI:_____

Referral Reason:_____ Date:_____

Other: _____