



Patient Referral Form

Referral Guidelines

1. To refer a potential patient, please complete this form and return it, along with a copy of the potential patient's identification card, insurance cards, and social security card (if available)
2. If Patient has a power of attorney, please notify power of attorney of the referral.
3. Referrals can be emailed to info@premiercounselingllc.org or faxed to 864-751-5834. Please include a contact number or email address to allow Premier Counseling to follow-up regarding the receipt of the referral.

Patient Demographic Information

Patient Name: _____ **DOB:** _____
SSN: _____ **Address:** _____
Ins & Policy #. _____

Referral Information

Reason for referral: _____

Patient Contact Number: _____

POA Contact Number (if applicable): _____

Referral Source Information

Date of Referral: _____ **Patient Aware:** YES/NO _____
Referring Person: _____ **Contact:** _____