PREMIER Counseling

Dedicated to Providing Quality Mental Health Services

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 #. _____ _____

(Please include a copy of cards) _____

Referral Information

Reason for referral: _____

_____

_____

_____

Patient Contact Number: _____

Patient or POA Email: _____

POA Contact Number (if applicable): _____

Referral Source Information

Date of Referral: _____ **Patient Aware**: YES/NO

Referring Person: _____ **Contact:** _____

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