HEALTHCARE PROVIDER REFERRAL

Cherokee Rose Counseling & Consulting, LLC

Cumming, GA | Dacula, GA | Virtual throughout Georgia

FAX COMPLETED FORM TO: (678) 404-2853

REFERRING PROVIDER

Practice / organization

Referring provider / credentials

Office phone

Office fax

Contact person / email (optional)

PATIENT INFORMATION

Patient full name

Date of birth

Patient phone

Parent / guardian (if minor)

Insurance carrier or self-pay

REASON FOR REFERRAL

Brief reason / presenting concerns (include diagnosis if relevant)

Additional records or clinical information are welcome. Please fax relevant supporting documents with this form.

SERVICES & LOCATION PREFERENCES

- ☐ Individual
- ☐ Couples / family
- ☐ EMDR / trauma
- ☐ Perinatal
- ☐ Other / unsure

If other, specify (optional)

Preferred location / format (select all that apply):

- ☐ Cumming - in person
- ☐ Dacula - in person (Tanya only)
- ☐ Virtual

PATIENT CONTACT & ADDITIONAL INFORMATION

- ☐ Patient is aware of referral
- ☐ Patient may be contacted for scheduling

Additional notes / preferred contact method / scheduling considerations

Referring provider signature:

Date:

For outpatient referrals only. Do not use for emergencies or urgent psychiatric evaluation.
Please verify fax number before transmitting PHI. Specially protected records may require additional consent.
Referral does not guarantee acceptance or establish a treatment relationship.