HOLISTIC GROWTH
Integrative Mental Health Counseling –Multicultural Consulting
Complementary and Alternative Therapies – Life Coaching

Tel. 808-824-0721 FAX 828-933-1134

REFERRAL FORM

Thank you for your referral. We look forward to partnering with you in your patient's care. Please complete the form and submit it via fax only at 828-933-1134.

Date:_____Referred by:_____Phone #:

Referring Provider #:_____Provider NPI:_____

Reason for referral:_____

_____

Client Information: _____Child ___ Adolescent __ Adult Language: ___ English __ Spanish

Client Name (*First, MI, Last)*: _____

DOB:_____/_____/_____ Gender_____Male _____Female SSN #:_____

Client Address:_____City_____State_____Zip

Primary Phone #:_____Alt. / Phone #:_____

For Children Only (please complete the following):
Parent/Guardian Name (s)/ Relationship:
Primary Phone #:_____Alt. Phone #:_____
Diagnosis/ICD: _____
Service/Specialty Requested: _____

Holistic Growth is an out of network service. We offer outpatient integrative therapy services at out office location.

ORDER FOR MEDICAL NECESSITY (by referring provider)

Directions: PLEASE PROVIDE SIGNATURE FOR SERVICE ORDERED. EFFECTIVE DATE SHOULD BE THE DATE THE SERVICE WAS DETERMINED NECESSARY.

The services indicated below have been determined to be medically necessary for the client named above. This order for service does not indicate supervision of service provided or that the MD or Psychologist, NP, or PA has any role other than determining medical necessity, unless other points specified elsewhere (e.g.. treating psychiatrist).

Service Requested	Date of Order & Signature	Print Name Or Stamp	Signature of MD PhD, NP or PA with credentials – No Stamps
Outpatient Services			