

 **Fax:** **(678)388-9244**  **Email:** **referral@scs-helps.com** **Phone: 800-552-4357**

**REFERRAL REQUEST**

***Please attach a copy of the front and back of the patient’s insurance card***

**From:  Date:  Phone: **

**Patient’s Legal Name: **

**Responsible Party’s Legal Name: **

**Street Address: **

**City:  State:  Zip: **

 **Insurance:  Insurance ID#: **

**Subscriber’s Name:  Subscriber’s DOB: **

**Phone:** (H):  (M): 

**Email: **

**Referring Reason:** [ ] Attention Deficit [ ] Anxiety [ ]  Depression ☐ Behavioral Problems:

***\*Note all referrals will be given an Initial Diagnostic Assessment based on symptoms identified by the referring agency.***

 [ ] Home

 [ ] School

 [ ] Community Conduct

[ ] Other

**Please Note: **

**Does this Person Currently See A Counselor** [ ] Yes [ ] No

**Comments: **