

**Fax:** **(678)388-9244**  **Email:** [**referral@scs-helps.com**](mailto: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: **