Cognitive & Behavioral
Health Center of Charleston, LLC

Physican's Referral & Feedback Form

Please Fax to: 843-501-7542
For more information call: 843-501-7001

To Make a Referral, Please Complete Top Portion and Fax.

Date: _____ ( ) Initial ( ) Follow-up

Referring Physician Name: _____

Practice Name:_____

Fax: (____) _____ Phone: (____) _____

Patient's Name: _____ DOB:_____

Patient's Medicaid #: _____

Parent's Name (if minor): _____

Phone Number(s):_____

Address:_____

Reason(s) for Referral:_____

_____

_____
Referring Physician's Signature

Licensed Independent Practioner's Report

Date(s) Patient Seen: _____
( ) Patient did not make appointment.
( ) Patient made an appointment but did not keep appointment.
( ) Patient not seen within 60 days.

Initial Diagnoses:
1. _____ 2. _____

Recommendations: _____

_____

Follow-up Arranged or Provided by C&B:	**Other Care Needed:**
( ) Further diagnostic testing_____ ( ) Individual psychotherapy ( ) Family psychotherapy ( ) Group psychology ( ) Return visit_____	( ) Medication management ( ) Referrals recommended ( ) Follow-up recommended ( ) Lab tests ( ) Other:_____

Signature_____ **Date**_____

Name _____ **Title**_____