jodi province
Counseling Services, PLLC

High School Mental Health Referral Form

DATE:_____ (Office Use Only: Provider):_____

NAME:_____
FIRST MIDDLE INITIAL LAST

ADDRESS:_____
CITY STATE ZIP

DATE OF BIRTH_____AGE_____GRADE:_____ HOME/CELL PHONE_____

LEGAL GUARDIAN/RELATIONSHIP_____

SCHOOL ATTENDING/GRADE_____

EMERGENCY CONTACT/TELEPHONE_____

PRIMARY PHYSICIAN/TELEPHONE_____

CURRENT MEDICATIONS_____

ALLERGIES_____

NATURE OF CONCERN REQUIRING COUNSELING

_____

_____

INSURANCE INFORMATION

INSURANCE COMPANY:_____NAME OF INSURED/Relationship to client:_____

INSURED'S SSN#:_____INSURED'S D.O.B_____

INSURED'S POLICY #:_____INSURED'S GROUP #:_____

INSURED'S EMPLOYER:_____AUTHORIZATION #:_____

1260 College Ave #1, Wilkesboro, NC 28697 • 336-818-0733 • 336-818-0734 (Fax) • jodi.province@gmail.com