Referral Form

Date of Referral ____/___/___

Referral Source:

_____
___

Referral Contact:

_____
___

Name:

_____
_____

Address:

_____
_____

_____
_____

Date of Birth: ___/___/___ **Sex:** _____
Insurance:_____

Preferred Location (circle): Franklin Waynesville Bryson City

Reason For Referral:

_____
_

_____
_____
_____
_____
—

Is client aware of referral to Ridgeline Therapeutic Collaborative, PLLC? Y / N

For Agency Only: Date Received__/__/__
Date Contacted __/__/__

Therapist assigned:_____

Your signature below provides consent for communication to occur between the referral source and RTC,PLLC.

Client Signature _____ Date __/__/__

Referral Signature _____ Date __/__/__

Please fax the completed referral form to Attention: REFERRAL

FAX: 828-604-9014

Please allow up to 5 business days for client to be contacted for service screening.

For Agency Only: Date Received__/__/__
Date Contacted __/__/__

Therapist assigned:_____