



PIONEER @UNSELING

REFERRAL FORM

Referral Fax: 276-880-0036 | Preferred Email Communication: cindy.davis@pioneerounselingcenter.com

CLIENT DEMOGRAPHIC INFORMATION

Client Full Name: _____

Date of Birth: _____ Age: _____

Gender: _____

Phone Number: _____

Email Address: _____

Home Address: _____

PARENT / GUARDIAN INFORMATION (IF CLIENT IS A MINOR)

Parent/Guardian Name: _____

Relationship to Client: _____

Guardian Phone Number: _____

Guardian Email Address: _____

Guardian Address (if different from client): _____

INSURANCE INFORMATION

Insurance Company: _____

Member ID Number: _____

Group Number: _____

Policyholder Name: _____

Policyholder Date of Birth: _____

Relationship to Client: _____

Policyholder Phone Number: _____

Policyholder Address: _____

SERVICES REQUESTED (Please check all that apply)

Counseling Services

Psychiatric Medication Management

Spravato® Treatment

Medical Marijuana Certification

GeneSight® Genetic Testing

EMDR Therapy

ATTACHMENTS INCLUDED (Please check all that apply)

Most Recent Office Note

Recent Labs

Medication List

Insurance Card

Psychological Testing / Assessments

Additional Records

REASON FOR REFERRAL

Presenting Concerns / Symptoms: _____

Diagnosis (if applicable): _____

Relevant Clinical Information: _____

REFERRING PROVIDER INFORMATION

Referring Provider Name: _____

Practice / Facility Name: _____

Phone Number: _____


Fax Number: _____

Email Address: _____

Preferred Method of Communication:

Phone Fax Email

PROVIDER COMMENTS / ADDITIONAL INFORMATION

 Please include the patient's current email address whenever possible to help expedite portal setup and intake paperwork.
 Please fax referrals securely to 276-880-0036.
 For referral questions or coordination of care, email communication is preferred: cindy.davis@pioneerounselingcenter.com