544 Mulberry Street Suite 107, Macon, GA. 31201
Phone (478)254-8555/Fax 478-254-8601
Bridgestoneservices94@gmail.com

REFERRAL FORM

Today's Date: ______________________________

First Name: ________________________MI____ Last Name_____________________ DOB:_______________

Address (Street, City, State & Zip Code): ____
____ _______

Age: ____ Social Security Number:____

Home Phone#: ________________________________ Cell Phone#: ________________________________

May we leave a message? Yes______ No_______

Referral Source: Self_____ Other (Specify) ____

Contact Phone#/Email Address (If Applicable): ____

REASON FOR REFERRAL/COUNSELING: Presenting Problems/Concerns/Issues: How Long?

MEDICAL/PSYCHIATRIC HISTORY
Treatment History (Please include diagnosis; current or past counseling, treatment; psychiatric hospitalizations, ect.) ____

____

Therapist/Practitioner Name (If Applicable):_______________________ PH#_____________________

Medications (Psychotropic Only):___________________________________ Allergies: _______________

COMPLETED PSYCHOLOGICAL EVALUATION? Yes:_____ No:_____, **If Yes, mail it to office or have client bring with him/her during initial visit**

METHOD OF PAYMENT FOR SERVICES: _____________________________**MEMBER ID/MEDICAID#**(If Applicable) ____

*****PLEASE NOTE: Driver's License or Photo ID required during initial visit** *(for identification purposes)*