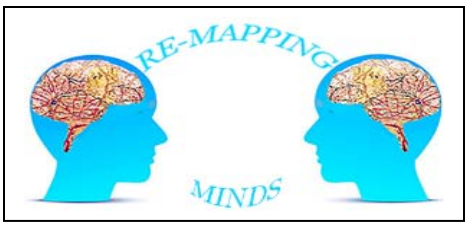
REFERRAL FORM

Please complete the following and send this form, and any additional information to:

info@remappingminds.com or fax to 833-691-7892
ATTN: Front Desk, Office number: 770-599-7512
125 Lee Byrd Rd.
Loganville GA 30052



DEMOGRAPHICS

Client Name: _____ **Date of Birth/Age:** _____

Insurance Type: _____ **Policy Number:** _____

Client Address: _____ **Phone Number(s):** _____

City/State/Zip: _____ **Caretaker name:** _____

Referring Person/ Agency _____

Phone Number: _____

Email: _____

REQUESTED SERVICES (Mark all that apply)

Assessment Only (with recommendations only, no services)

☐ Child
☐ Adult

Assessment (with services – specify services desired below)

☐ Child
☐ Adult

Services Requested (assessment required; services based on medical necessity and as authorized by payment source)

Psychotherapy
☐ Individual
☐ Family
☐ Group

Rehabilitative Services
☐ Basic Skills Training
☐ Psycho-Social Rehabilitation

Biofeedback/neurofeedback
☐ Psychological Testing
☐ Sessions

REASON FOR SEEKING SERVICES

Concerns:

Symptoms/Behaviors/Issues at Home:

Symptoms/Behaviors/Issues at School/Employment:

Symptoms/Behaviors/Issues in the Community:

Would you like monthly update?

Please attach any relevant information you might think is necessary.