SYNERGY COUNSELING

OF GREENWOOD

Your Path To A Better Life

# REFERRAL FORM

Referring Agency: ___________________________________ Referral Date: ____________

Referral Source Name: ________________________ Source Contact Number: ____________

Referred Client Information:

Last Name: _________________ First Name: ___________________ M.I.: ________

Address: ______________________________________________________________

City: ____________________ State: ______________________ Zip Code: _____________

Phone Number: _____________________________ Please Check One: Home __ Cell __ Work __

SSN: _____________________________ DOB: Month ________ Day _______ Year ________

Primary Form of Insurance: __________________________________ ID#: _________________

* Please keep in mind that currently we are ONLY in network with First Choice Select Health Medicaid, Healthy Connections State Medicaid, and Molina Healthcare. We apologize for any inconvenience that this may cause. *

Will the agency be paying for the services? Please check one: Yes ____ No ____ Partial Payment _______ (What amount is the client responsible for?)

SYNERGY COUNSELING OF GREENWOOD, LLC
Physical Address: 101 Cambridge Ave. E, Greenwood, SC 29646
Mailing Address: PO BOX 49895, Greenwood, SC 29649
Tel: (864) 223-2243 | Fax: (864) 223-3044
Email: admin@synergycounselinggreenwood.com | Website: synergycounselinggreenwood.com

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Please describe in as much detail as possible your reasons for referring this client: ______________________________________________________________________
______________________________________________________________________
______________________________________________________________________
______________________________________________________________________
______________________________________________________________________
______________________________________________________________________
______________________________________________________________________

Treatment Services Requested, please indicate number of sessions approved and how many per week:

| | | | |
|---|---|---|---|
| Mental Health Counseling: | Anger Management: | Domestic Violence (Victim): | TESTING: Psychoeducational Assessment–Cognitive Only |
| Substance Abuse Treatment: | Couples Counseling: | Domestic Violence (Aggressor): | TESTING: Full Psychological Assessment-Cognitive and Personality |
| Parenting Classes: | Medication Management: | Grief Counseling: | Co-Parenting Classes: |
| Family Counseling: | Other: | Other: | Telehealth Visits: Y/N |

Please Attach ANY Supporting Documents:

- Court Order
- Safety Plan
- Medical Release Form
- Previous Records

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