Healing Waters Counseling Center, LLC
P.O. Box 426
Cedar Bluff, VA 24609
276-963-0111

REFERRAL FORM

DATE OF REFERRAL: _____

NAME: _____

DOB: _____

PARENT/GUARDIAN (If Applicable): _____

CONTACT PHONE/CELL #_____

ADDRESS: _____
_____

INSURANCE: _____

INSURANCE ID#: _____

INSURANCE GROUP ID# (if applicable): _____

SERVICES BEING REQUESTED:

☐ OUTPATIENT THERAPY (All Ages)

☐ PSYCHIATRIC SERVICES (All Ages)

☐ PSYCHOLOGICAL TESTING (Ages 6 – Adulthood)

☐ INTENSIVE IN-HOME SERVICES (Ages 3-21)

☐ MENTAL HEALTH SKILL-BUILDING SERVICES (Ages 18+)

Any Additional Info: _____

REFERRAL SOURCE: _____
(NAME) (AGENCY)

CONTACT NUMBER: _____

Please fax this form and any additional clinical information to 276-963-0005.