HEALTHY SOLUTIONS
COUNSELING & CONSULTING, LLC

1424 7th Avenue SE
Decatur, AL 35601
(256) 822-2909
www.HSCCofAL.com

Referral Form

General Client Information

_____ _____
Last Name *First Name* *MI* *Date of Referral*

_____ _____
Street Address *Date of Birth*

_____ _____
City *State* *Zip* *Social Security Number*

_____ _____
Primary Telephone Number *Alt. Phone Number*

_____ _____
Parent/Guardian/Emergency Contact Name *Emergency Contact Number*

_____ _____
Primary Care Physician *Referred By*

Reason for Referral (Medical Professionals Please Include Diagnostic Impression)

_____

_____

_____

MEDICAID recipients must have a current EPSDT with diagnostic impression and recommendation for mental health counseling services attached to referral form.

Primary Insurance Information

Primary Insurance: _____ Policy Holder:_____

Policy Holder Date of Birth: _____ Relationship:_____

Policy Holder Address: _____

City: _____ State: _____ Zip Code:_____

Policy Number: _____ Group Number:_____

Referring Professional Signature: _____