Filled with Joy Counseling Center

Therapy Referral Form

Naomi Brown, MA, LCMHC, NCC

(P) 336-355-0779 (F) 336-792-9167 (E) naomibrown@filledwithjoylc.com

Date of Referral: _____

Referred By (Name & Title): _____

Organization/Practice (if applicable): _____

Phone: _____ **Fax:** _____

Email: _____

Client Information

Client Name: _____

Date of Birth: _____

Parent/Guardian Name (if under 18): _____

Address: _____

City, State, ZIP: _____

Phone Number: _____

Email: _____

Insurance Information

Insurance Provider: _____

Policy Number: _____

Subscriber Name & DOB: _____

Reason for Referral

[ ] Anxiety

[ ] Depression

[ ] Trauma/PTSD

[ ] Relationship Concerns

[ ] Stress Management

[ ] Grief/Loss

[ ] Parenting/Family Concerns

[ ] Other: _____

Brief Description of Concerns/Presenting Issues:

_____

_____

_____

Urgency Level

[ ] Routine (Non-urgent)

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[ ] Urgent (Requires prompt follow-up)

Referrer Signature: _____ Date: _____

Please fax completed form to: 336-792-9167

or email securely to: naomibrown@filledwithjoylc.com