BROWN CLINICAL SERVICES

Referral Form

Licensed Independent Practitioner Services

The recipient or guardian of recipient has requested counseling services from our agency. Please review and complete the required information for services.

Recipient: _____ DOB: _____

Referred To: Brown Clinical Services

Office Address: 201 E. Woodlawn Rd, Suite 225 E
Charlotte, NC 28217-2229

Requested services: ☐ Clinical Intake ☐ Mental Health/ Behavioral Health Assessment ☐ Individual and/or Family Therapy

I hereby authorize Brown Clinical Services to submit referral form to required health care professional for the purpose of accessing clinical services. I also authorize Brown Clinical Services to release results of intake and/or assessment to the referring health professional for the purpose of coordination of clinical services and obtaining required service order to continue services.

_____ _____
Recipient Signature *Date*

_____ _____
Legal Guardian signature if recipient is under 18y/o *Date*

Doctor Signs Below

Physician Name (please print name)		Facility Name
Address		
City	State	Zip
Physician Signature & Credentials	**Date**	**Facility NPI: (Required for services)**