Therapy Referral Form

Therapy Provider: Lauren Blackburn, MSW, LCSW

☐ **Pinehurst**

285 Olmsted Blvd, Suite 10
Pinehurst, North Carolina 28374
Phone: 910-295-7246
Fax: 910-222-3168

Patient Name: _____ **DOB:** _____

Address: _____

Phone: _____ **Insurance:** _____

Diagnosis: _____ **ID:** _____

Reason for referral/Presenting Problem: _____

_____

_____

Significant Medical History: _____

_____

_____

Referring Provider Information:

Name: _____ **Practice:** _____

Address: _____

Phone: _____ **Fax:** _____

Email: _____

OFFICE USE ONLY

Appointment Date: _____

Medical History/Treatment Notes Received: ☐ Yes ☐ No Referring Provider Notified: ☐ Yes, Date: _____ ☐ No