1500 Lady St. Columbia, SC 29201
803-779-1995

Referral for Psychiatric Services

Date: _____

Patient Referred: _____ **DOB**: _____

Patient Phone Number : (_____)_____ **Patient Guardian: _____**

Reason for Referral:_____

_____

Diagnosis: _____

Current Medications: _____

_____

Patient's Insurance: _____

Name of Provider Referring: _____

Previous Psychiatrist (if applicable): _____

For Physicians:
Please include last labs and progress notes.

For LPC/LMSW:
Please ensure patient has been seen by primary care physician within the last twelve (12) months. Include the patient's initial intake note and last progress note.

Send referral and documents via secure email to support@christiancounseling.ws or fax to 803-779-7881.

FPCCCC External Psych Referral V 1.1 05172023

Fax Cover Sheet

Confidential