Cognitive & Behavioral Health Center of Charleston

Physician's Referral Form

Please Fax to: 843-501-7542
For more information call: 843-501-7001

Date: _____/_____/_____ ( ) Initial or ( ) Follow-up

Provider Information

Referring Physician Name: _____

Practice Name:_____

Fax: (_____) _____ Phone: (_____) _____

Patient Information

Patient's Name: _____

DOB:_____

Patient's Medicaid #: _____

Parent's Name (if minor): _____

Phone Number(s):_____

Address:_____

Reason(s) for Referral:_____

_____

_____

Referring Physician's Signature

Cognitive & Behavioral Health Center of Charleston, LLC
29 Leinbach Dr., Suite B4 • Charleston, SC 29407
p (843) 501-7001 • f (843) 501-7542