Crossroads
COUNSELING CENTER

Adult Referral

Doctor's Office: _____ Date: _____

Name: _____ DOB: _____

Address: _____

Phone Number(s): _____

Insurance: _____

Insurance Policy Number: _____

Medicaid Number (if applicable): _____

Current Significant Issues: _____
_____
_____
_____

Service you are requesting:

- ☐ Counseling/Therapy
- ☐ Psychological Evaluation (please specify)
  - IQ
  - Mood Disturbance
  - Autism Spectrum
  - Personality
  - ADHD* vs. _____
    *Medicaid will no longer pay for testing if the only diagnostic question is ADHD. If client has Medicaid, please note the differential diagnosis in consideration. (Ex. ADHD vs. Anxiety, ADHD vs. Mood Disorder, etc.)
- ☐ Other: _____

Nurse/Physician/PA making referral: _____

Phone #: _____

Crossroads Counseling Center, Inc.
858 2nd Street NE, Suite 101
Hickory, NC 28601
Phone (828)327-6633 Fax (828)327-3385

Revised 10/2013