Crossroads
COUNSELING CENTER

Child/Adolescent Referral

Doctor's Office: ____ Date: _______________

Child's Name: ____ DOB: _______________

Caretaker's Name & Relationship: ____

Caretaker's Address: ____

Caretaker's Phone Number(s): ____

Insurance: ____

Insurance Policy Number: _________________________________

Medicaid Number (if applicable): _______________________________________

Current Significant Issues for the Child: ____
____
____
____

Service you are requesting for the child:

- ☐ Counseling/Therapy
- ☐ Psychological Evaluation (please specify)
  - o IQ
  - o Mood Disturbance
  - o Autism Spectrum
  - o Personality
  - o 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.)
- ☐ Psychiatric Evaluation
- ☐ Other: ____

Carolina Access #: ______________________
NPI #: ____________________________

Nurse/Physician/PA making referral: ____

Phone #: ___________________________

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