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)
  - 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.)
- □ Psychiatric Evaluation
- □ Other: _____

Carolina Access #: _____
NPI #: _____

Nurse/Physician/PA making referral: _____

Phone #: _____

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