



1175 Revolution Mill Drive, Suite 29-2  
Greensboro, NC 27405  
(336) 457-0827

### Referral/Authorization for Counseling Services

Date: \_\_\_\_\_

Patient Name: \_\_\_\_\_

Date of Birth: \_\_\_\_\_

Medicaid ID # & County: \_\_\_\_\_

Other Insurance Info: \_\_\_\_\_

Legal Guardian Name: \_\_\_\_\_

Guardian Phone #: \_\_\_\_\_

Referring Provider Name: \_\_\_\_\_

Referring Practice Name: \_\_\_\_\_

Provider Phone #: \_\_\_\_\_

Provider Fax #: \_\_\_\_\_

Provider Address: \_\_\_\_\_

Carolina Access/Group NPI: \_\_\_\_\_

Reason for Referral: \_\_\_\_\_

\_\_\_\_\_

Provider Signature: \_\_\_\_\_

Date: \_\_\_\_\_

*Thank you for your referral. I look forward to collaborating in the care of your patient.  
Please email this form to [amandakirbylpc@gmail.com](mailto:amandakirbylpc@gmail.com) or fax to 877-616-4840 and I  
will be happy to contact the patient to schedule an appointment.*