Access Community Center
106 Fabrister Lane, Ste D
Lexington, SC 29072
Phone: 803.957.0794
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ACCESSCommunity
center for youth & family enrichment

Client Referral Fax Form

Referring Person / Agency Information

Today's Date: _____ **Person Making Referral:** _____

Referring Agency: _____

Referring Agency Phone: _____ **Referring Agency Fax:** _____

Client Identifying Information

Client Name: _____ **Male / Female** (circle one)

Date of Birth: _____ **Social Security Number:** _____

Diagnosis (if any): _____

Reason for Referral: _____

Client Contact Information

Guardian Name (If minor): _____

Home Phone: _____ **Cell Phone:** _____ **Work Phone:** _____

Address: _____

City: _____ **State:** _____ **Zip Code:** _____

Insurance / Reimbursement Information
(Please include a front & back copy of insurance card. If insurance is Medicaid, please include client's Medicaid identification number.)

Primary Insurance: _____ **ID#:** _____

Insured Name: _____ **Insurance Referral/Authorization #:** _____

Recommended Services (Check all that may apply)

_____Diagnostic Assessment _____Individual Therapy _____Group Therapy _____Family Therapy

_____Rehabilitative Psychosocial Services _____Behavior Modification _____ Family Support

Additional Comments

_____

_____

_____

_____

Please include all pertinent documents associated with this referral. MNS or IPOC may be submitted in the place of this form.