

Access Community RBHS
106 Fabrister Lane, Ste D
Lexington, SC 29072
Fax: 866.576.2589
Phone: 803-447-0001



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.