Referral Cover Sheet

QC Psychology, PLLC

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Referring Provider/Agency: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Referral Coordinator:

Phone Number:

Guardian Name:Guardian Phone number:

Guardian Email Address:

Who is responsible for scheduling?

Patient Name:

DOB \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Age: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Gender: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Primary Insurance (circle one): Blue Cross, Aetna, Medicare, Medicaid

Insurance ID #:

Does the patient have a secondary insurance? YES or NO If so, provide name of insurance company: \_\_\_\_\_\_

Secondary Insurance ID #:

Reason for referral:

Service needed (circle one): Neuropsychological Evaluation | Psychological Evaluation |

Re-evaluation of DD (with interview, IQ, and adaptive) | Evaluation for ADHD/Learning Disability | Counseling/Psychotherapy

Records attached:

Neurology notes | Prior Psychological Evaluation | Physician visit notes | Other:

If you have any questions regarding your client or patient, please call us. Thank you for the referral. This correspondence my contain information that is confidential and/or legally privileged. It is intended only for the use of the individual(s) and entity named as recipients in the message. If you are not the intended recipient, please notify the sender immediately and delete the material from any computer. Do not deliver, distribute, or copy this message and do not disclose its contents or take any action in reliance on the information it contains.