ASHEBORO BEHAVIORAL MEDICINE, PLLC

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REFERRAL FORM -- FAX TO 336-232-1786

From:	Date:
Re: Referral	FAX # of Referral Coordinator:_____ Name of Referral Coordinator:_____
Name of Patient being referred;	
Parent's Name(s) (if patient Is a child):	
Phone #s where someone can be contacted for scheduling:	
Reason for Referral:	
Any priority when It comes to scheduling?	
Copy of Insurance Card Attached: ☐ yes **Copy of Demographics Attached:** ☐ **YES**	

FAX- ACTION TAKEN

To:	FAX:
From: Asheboro Behavioral Medicine	Date:
☐ Pt, Declined therapy Reason (If one given) ☐ Pt.'s insurance is out of network so cannot see pt. ☐ Other:	☐ Left several msgs for pt, & pt has not returned calls ☐ unable to leave msgs ☐ Pts phone Is not working
PATIENT HAS AN APPOINTMENT ON _____ With Christine Glarmo, Ph.D., Psy,D	