INJURY TRAUMA COUNSELING

Serving all of Florida
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Mental Health Referral Script

*Fillable form

Date: _____ Referring Provider: _____

_____ _____ _____
Patient Name DOB Phone #

_____ _____
Mailing Address (Complete) Email

_____ _____ _____
Health Insurance Plan Policy ID Phone

_____ _____ _____
PIP Insurance Carrier Claim # DOL

_____ _____
Attorney Name Phone #

Reason for Referral:

□ Evaluation

_____
_____
_____

DX: _____

Include a copy of a government issued photo ID to confirm identity. *

_____ _____
Referring Physicians Signature Date Signed