Coastal Carolina Professional Counseling Services
PA: 209 N. 35th Street, Suite B-3, Morehead City, NC, 28557
MA: PO Box 460, Newport, NC, 28570
Office Phone: (252) 777-2016
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scott.ccpcs@gmail.com

Referral Form

Referring Provider:_____

Referring Provider NPI#: _____

Reason for Referral: _____

Type of Counseling requested: __ Individual __Couple __Child/Adolescent

Name_____ DOB_____

Address_____

Best Contact Number:_____

Insurance:

Primary:_____ Secondary:_____

Policy/Subscriber #:_____ Policy/Subscriber #:_____

Group #:_____ Group #:_____

Please send most recent progress notes, including medications, and any required authorizations with this referral sheet.

We will contact the patient directly to schedule and will make every effort to see your patients as soon as possible. Once scheduled, we will notify your office of the appointment date and time.

Thank you for your referral!

For office use only:

Attempts to contact: 1st _____ 2nd _____

Provider Name: _____

Appointment Date/Time_____

Office Contacted _____