Redwood Counseling, LLC
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(256) 258-8579
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Referral Form

Patient Name:	DOB: Age:
Address:	Phone:
Email:	

Insurance Information

Aetna BC/BS Cigna United Healthcare	Contract #
Group #	Policyholder Name:
Policyholder Employer	Relationship to Policyholder: Self Spouse Child

Reason for Referral

☐ Anxiety	☐ OCD	☐ Trauma
☐ Depression	☐ Grief/Loss	☐ Behavioral
☐ Other mood d/o	☐ Chronic stress	Other:

Please list major concerns, psychiatric history (if any/known):

Current Medications:

Person completing this form:	Phone:
Referral source name	Email:

FOR OFFICE USE ONLY:

Appt day/time:	Appt in scheduler: Appt. refused:
Staff initials:	Date: