Breathe Life Counseling, LLC
Referral Form for Psychological Evaluation

REFERRAL SOURCE

Name & Credentials: _____

Practice: _____

Phone: _____

Address: _____

Email: _____

Fax: _____

CLIENT INFORMATION

Name: _____

Date of Birth: _____

Phone Number: _____

Email: _____

Dates of previous testing, who did it, what purposes? :

_____

REFERRAL QUESTIONS (ie- why are we testing & for what?)

1. _____

2. _____

3. _____

Needed for court purposes? Yes or No

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If you are a mental health professional, please attach your own diagnostic assessment and most recent progress note to provide additional context and information.

This can be faxed to (843) 892-0394 or emailed securely to welcome@breathelifecounseling.com. After reviewing this information, Katie Gross will be in contact with you within 72 hours (3 business days) to discuss scheduling the first appointment. She reserves the right to decline the referral and not proceed with the testing administration for any reason.