CLARITY COUNSELING
CENTER
YOUR MIND, BODY & SOUL

Three Easy Steps to a Seamless Mental Health Referral

1. Fill out form and fax to **910-447-4421**or scan and send to **clarityoffice@claritywilmington.com**
2. We will make **3 attempts** to reach the client (1st attempt will be made within **24hrs** of our receiving the fax. 2nd / 3rd attempts will be made within **one week**.
3. We will notify you when/if the client has been scheduled successfully, or if **3 attempts** have been made and we were unable to reach the client.

Referral Source Name: _____

Referral Source Phone #: _____ **Fax #:** _____

Client's Name (as it appears on insurance card): _____

Preferred Name: _____ **DOB:** _____

Gender (circle one): F / M / Tra **SSN:** _____ **Marital Status:** S / M / D / W

Address: _____ **City:** _____ **Zip:** _____

Phone: _____ **Email:** _____

Insurance Company: _____ **Subscriber's Name:** _____

Subscriber's DOB: _____ **Member ID / Policy #:** _____ **Group #:** _____

Type of Services?
Psychiatrist / Counselor

Reason for referral:_____

****If the client is a minor, please list as much of guardian's info as you have:**

Name: _____ **DOB:** _____

Address (if different): _____

Cell Phone #: _____ **Home Phone #:** _____

Email Address: _____