ROOTS TO WELLNESS
PLLC

Client Referral Form

Incoming/ Outgoing Referrals To RTW

Referral Source:_____ Relationship to Client:_____Tele#:_____

Address:_____City: _____ State:_____Zip:_____

Client Information
Name:_____Age:_____Gender:_____DOB: _____

Race:_____Insurance Type/#:_____Phone: _____

Address:_____City:_____

State:_____Zip: _____Email address:_____

Insurance Policy Holder
Name:_____DOB: _____

Address:_____

Parent/Guardian:_____Phone: _____

Address:_____
Custody order Yes☐ No ☐ Provided custody order to the office Yes☐ No☐ Date provided _____
Have you been seen by another provider this year for this concern? Yes☐ No☐ Last date seen _____
Name and phone number for the last provider seen: _____
Client declines consent for coordination with PCP _____

Preferred appointment type
___ In-person
___Virtual

Staff Use only: [Virtual Therapy Only) : Telehealth Approved for Client Yes ____ No ____

School, Agencies, and Professionals (PCP) Already Involved:

Name	Agency	Phone

Presenting concerns / reason for referral:

Signature:_____ **Date:** _____

Roots to Wellness ,PLLC 7 Corporate Center Ct. Ste.B Greensboro, NC 27408
Phone (336) 502-5107 • Fax (336) 790-1269

Please fax completed referral form and supporting documentation.