**Jennifer K. Coleman, PhD, LP**
**Licensed Psychologist**
**Coleman Child and Family Services, PA**
**2460 Delaney Ave, Wilmington, NC 28403**
**Phone: 910-202-9113; Fax: 910-202-9289**

# REFERRAL REQUEST

Patient Name: _____ DOB: _____

**WHO has MEDICAL DECISION-MAKING RIGHTS for the client?** *(circle all that apply)*

**Biological Mom Biological Dad DSS** (County)_____ Other: _____

Parent/Guardian Name & Phone Number: _____
***(If DSS is involved, please provide name & contact number for social worker.)***

Residential Address: _____

Resides with (*list all adults living at above address)*: _____

Referring Provider Name & Contact Info: _____

How long has this client been involved in your agency? Please explain your involvement:

_____

_____

***REFERRAL DETAILS:***

***Insurance Provider:*** _____

**SPECIFIC QUESTIONS the team would like answered during the evaluation process for psychological evaluation or issues to address in therapy if this is a referral for therapy: (*REQUIRED*)**

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***PLEASE ATTACH MOST RECENT medical note or Comprehensive Clinical Assessment to this referral and fax or email to Julie at 910-202-9289 or jencolemanpsych@gmail.com.**

**If the child/adolescent is not in biological parent custody or biological parents are not together, scheduling will not occur until current custody documents are provided.**

**We will send follow-up confirmation as soon as possible.**

**Thank you for your collaboration! Jennifer Coleman, PhD, LP**