The Saluda Counseling Center
2400 West Main Street
Rock Hill, SC 29732
www.thesaludacenter.org
Phone: 803-327-6103 Fax: 803-328-5443

Outpatient Referral Form

Referring Provider:_____ Phone:_____

Practice/Agency Name: _____ Fax:_____

Patient Name: _____ DOB: _____

If patient under 18, Parent/Guardian Name: _____

Mailing Address:_____

Home #:_____ Work #:_____ Cell #:_____

Insurance (Required Field): _____ Policy #:_____

Subscriber Name (if other than Patient):_____

Relationship to Subscriber: _____ Subscriber DOB: _____
Please include a copy of the card, if available

Services Requested (Please check any that apply):
___ Medication Evaluation/Management
___ Individual Therapy/Counseling
___ Group/Family Therapy/Counseling
___ Couples Therapy/Counseling

Reason for Referral: _____

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