ICGH

TREATMENT CENTERS

www.integratedcarehickory.com

Client Referral Form

Date: _____

Referring Agency / Clinician: _____

Referring Phone Number: _____

Client Name: _____ DOB: _____

Parent/Guardian Name (if under age 18): _____

Primary Phone number: _____ Secondary Phone Number: _____

Address: _____

Insurance Carrier: _____ Policy Number*: _____
*Photocopy of the patient's insurance card may be attached instead.

Diagnosis / Reason for Referral: _____

_____

_____

_____

Current Medication List: _____

_____

_____

_____

Other Information: _____

_____

Fax to (828) 345-0387 or scan and email to contact@integratedcarehickory.com to submit