Aspiring Hearts Counseling, PLLC
Mending Hearts... Changing Lives.

# Physician Referral to Behavioral Health Services

Date: _____ MID/Ins. # _____

Patient's Name: _____ DOB: _____

County: _____ Phone: _____

Payer Source: ☐ Medicaid ☐ Health Choice ☐ Private Insurance ☐ Self Pay

Legal Guardian: _____ Phone: _____

*This patient is currently receiving medical care services at our practice and is in need of a Behavioral Health Assessment from you/your agency*

**Referring/Primary Care Provider's Name:** _____

Practice Name: _____

Address: _____

Phone: _____ Fax: _____ Email: _____

**Carolina Access Referral NPI # (Required):** _____

**Referral Request:**

Specific Concerns/Requests/Recommendations:

**The Following Patient Information is Attached:**

☐ Medical Diagnosis(es)
☐ Most Recent History and Physical
☐ Current Medication List
☐ Recent Lab Work
☐ Pain Agreement (If Applicable)
☐ Other _____

**Signature:** _____
**(Physician / Physician Assistant / Nurse Practitioner)**

*Thank you for agreeing to evaluate this patient.*

**Please Fax this completed referral to Aspiring Hearts Counseling at 1-888-325-6160**
**Or Return it to the offices of Aspiring Hearts Counseling**

16 W. Martin St., Suite 401 ♥ Raleigh, NC 27601 ♥ 919-538-3458 ♥ Fax: 1-888-325-6160 ♥ info@aspiringhearts.com
www.aspiringhearts.com