



Carolina Behavioral Health Services

Date _____ Referred by _____

Contact Person _____ Contact Number _____

Name of Client _____ DOB _____

Gender _____ SS Number _____

Insurance Company _____ ID# _____

Reason For Referral: Individual Therapy Family Therapy Group Therapy
 Trauma Specific Treatment Tele-behavioral Health Parenting Classes

Presenting Problem: _____

Additional Information: such as (other agencies involved): _____

Signature: _____

You May Visit Website, Email, or Fax Referral Form
130 Broad Street Sumter, SC 29151
4100 N. Main Street (Suite 101) Columbia, SC 29203
Office Phone: 803-774-4377
(Fax) 803-774-4378
Email: carolinabehavioralhealth@gmail.com
www.mycarolinabehavioralhealth.com