NORTHWESTERN COUNSELING & SUPPORT SERVICES

Parent Child Center

Patient Information	Referring Provider Information
Name: _____	Provider Name: _____
Preferred Name: _____	Practice Name: _____
DOB: _____	Practice Address: _____
Parent/Guardian Names: _____	Practice Phone Number: _____
Address: _____	Practice Fax Number: _____
Best Contact Number: _____	Provider/Practice Email: _____
Email Address: _____	
Insurance Carrier: _____	
Policy # _____ Group # _____	
Policy Holder's Name: _____	
Policy Holder's DOB: _____	

☐ I, the referring provider, understand that neither NMC nor NCSS is not designed for urgent assessment of children and adolescents with acute safety concerns. Please contact your local Community Mental Health Center if needed for any urgent safety concerns.

WHAT IS THE MAIN CONCERN YOU WOULD LIKE ADDRESSED WITH THIS CONSULTATION?

_____
_____
_____
_____

PLEASE LIST ANY OTHER TREATMENT PROVIDERS/AGENCIES INVOLVED:

_____
_____
_____
_____

PLEASE SEND THIS COMPLETED FORM, ALONG WITH THE RELEASE OF INFORMATION, TO OUR FAX: 802-752-1993. Any questions can be directed to: NMCDevelopmentalClinic@nmcinc.org, 802-752-1992, NMC Developmental Clinic, Cobblestone, Suite 204, 133 Fairfield St, St. Albans, 05478

☐ Pertinent Medical Records (must have documented developmental concerns)

☐ Completed ROI from PCP and any other pertinent providers (Speech Therapy, etc)

REFERRING PROVIDER SIGNATURE: _____ DATE: _____TIME: _____