The FLEXMAN MYERS Clinic

*Professional Counseling Center*

**The Flexman Myers Clinic**
**2621 Dryden Road, Suite 202**
**Moraine, OH 45439**

**Phone: (937) 256- 5300**
**Fax: (937) 258- 4162**
**TheFlexmanMyersClinic@gmail.com**

# REFERRAL FORM

Referral Date: _____

Patient Name: _____ DOB: _____

Phone: _____ Address: _____

*Parent/Guardian Name:* _____ _____

Insurance Plan(s): _____

*Please include a copy of the patient's insurance card (front & back), most recent office visit notes, and current medication list.*

## REQUESTED SERVICE

**___ Neuro/Psychological Evaluation**

*Please mark associated concerns:*

- □ Attention/Focus
- □ Hyperactivity/Impulsivity
- □ Intellectual/Developmental Delay
- □ Learning Difficulty
- □ Behavioral Issues
- □ Depression
- □ Anxiety
- □ Other Mood Concerns
- □ Trauma
- □ Other: _____

_____

_____

**___ Individual Psychotherapy**

*Please mark associated concerns:*

- □ Depression
- □ Anxiety
- □ Other Mood Concerns
- □ Trauma
- □ Other: _____

_____

_____

**Referrals accepted for adults 18 – 65 years and children 6+ years.**

Additional Information: _____

_____

_____

Referring Provider Name: _____

Practice Name: _____ Phone: _____

Address: _____ Fax: _____

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