Outpatient Behavioral Health Referral Form

Practice Information
PIL Professional Counseling
522 S. Independence Blvd., Suite 102D, Virginia Beach, VA 23452
Email: contact@pilcounseling.com - Fax: 757-577-9434

Referral Source Information

- **Referring Professional Name:** _____
- **Credentials/Title:** _____
- **Organization/Agency:** _____
- **Phone Number:** _____
- **Fax Number:** _____
- **Email Address:** _____
- **Preferred Method of Contact:** ☐ Phone ☐ Fax ☐ Email

Client Information

- **Client Name:** _____
- **Date of Birth:** _____
- **Phone Number:** _____
- **Email Address (if applicable):** _____
- **Address (optional):** _____

☐ Client has been informed of and agrees to this referral

Insurance Information (if available)

- **Insurance Provider:** _____
- **Policy/Member ID:** _____
- **Authorization Number (if required):** _____

Reason for Referral

(Select all that apply)

☐ Individual Therapy
☐ Family Therapy
☐ Group Therapy
☐ Behavioral Health Assessment
☐ Other: _____

Presenting Concerns / Clinical Summary:

Risk & Safety Considerations

- **Current safety concerns:** ☐ Yes ☐ No
  If yes, please explain: _____
- **Recent hospitalizations or ER visits:** ☐ Yes ☐ No
  If yes, dates/details: _____

Additional Information / Attachments

(Assessments, treatment plans, discharge summaries, etc.)

Referring Professional Signature

Signature: _____
Date: _____

Submission Instructions:
Please submit this completed referral form via **fax to 757-577-9434** or **email to contact@pilcounseling.com**