CEDAR RIDGE
COUNSELING CENTERS, LLC

# Referral Form

Please complete this form for referring a child to Cedar Ridge Counseling Centers, LLC. Diagnosis of specific condition or disorder is not necessary for a referral.
Please send completed referral form and copy of insurance card to Cedar Ridge Counseling Centers, LLC.

## Parent/Child Contact Information

Child Name _____ DOB _____ Gender _____

Home Address _____

City _____ MD _____ Zip Code _____

Parent/Guardian _____ Relationship to Child _____

Primary Phone Number _____ Other Phone _____

## Pertinent Medical or Developmental Diagnoses

Please note any medical or developmental diagnoses that would be pertinent to treatment for patient.

_____

_____

## Reasons for Referral

*(Please check all that apply)*

☐ Depression ☐ Anxiety ☐ Eating Concerns

☐ Behavior Concerns _____

☐ Other _____

☐ **Patient willing to travel to see someone that specializes in need**

## Referral Source Contact Information

Person Making Referral _____ Date of Referral _____

Practice Name The Pediatric Center, LLC - Columbia

Address 5900 Waterloo City/State Columbia, MD Zip Code 21045

Phone 443-451-1600 Fax 443-451-1619

## Release of Information Consent

I, _____ (print name of parent/guardian or patient if over 18 years), give my permission for my health care provider (listed above) and Cedar Ridge Counseling Centers, LLC to share and communicate any and all pertinent information regarding, _____ (print child's name or write "self").

Parent/Guardian/Patient Signature _____ Date _____