CEH
CENTER FOR EMOTIONAL HEALTH®

REFERRAL FORM

Phone: (704) 237-4240
Fax: (704) 246-7190
Email: referrals@cehcharlotte

REFERRING OFFICE INFORMATION

Referring Office: _____

Ordering Provider: _____

Phone Number: _____ Fax: _____

PATIENT INFORMATION

First name : _____ Last Name: _____

DOB: _____ Gender: ☐ Male ☐ Female

If minor, Parent/Guadian Name: _____

Phone Number: _____

Home Address: _____

City: _____ State: _____ ZIP: _____

Insurance: _____ Member/Subscriber ID: _____

REASON FOR REFERRAL:

- ☐ Medication Management
- ☐ Therapy
- ☐ Substance Abuse
- ☐ Veterans Services

LOCATION REFERRED TO:

- ☐ Virtual
- ☐ Davidson
- ☐ Matthews
- ☐ Salisbury