REFERRAL REQUEST

Thank you for choosing Jill E. Millea, M.A., LPC
I look forward to partnering with you in your patient's care.

Jill E. Millea, M.A., LPC 1-860-215-6648 jillemillea@gmail.com

Date:_____
# of pages:_____
Routine:___ Urgent: ___

Referring Provider Information:
Referred by:_____
Practice/Group:_____
Phone:_____Fax:_____PCP:_____
Address:_____City:_____Zip:___

Patient Information: (Please provide copy of patient demographics/face sheet):
Last Name:_____First Name:_____MI:_____
DOB:_____Phone_____Gender:___M ___F ___T
Patient's Address:_____
City/State/Zip:_____

Reason For Referral:
Diagnosis: R/O_____ICD-10-CM_____
Type of Service Requested: ____Consultation ____2nd Opinion ____Follow up
____Individual Outpatient Therapy ____ Marriage & Family Therapy

Reason for Referral:_____
_____

Documentation Required (Please include with this form):
*Relevant clinical notes
*Proof of insurance
*Release of Information signed