

**REFERRAL FORM**

Brendan C. Engen, Psy.D ( ) Stephen Autry, LMFT ( ) Teresa Land, LCSW ( )

Urgent? ( ) Yes

**Patient Information**

Date: \_\_\_\_\_

First name:	Last name:	Middle:
Date of Birth:	Name of Guardian/Spouse/Relative:	
Street Address:	City:	Zip:
Home:	Cell:	Work:

**Referral Information**

Physicians Name	Staff Member:
Tel:	Fax:

**Patient Issues**

**Appointment Type**

ADHD/ADD		Psychological Evaluation
Development Disorder		Psychotherapy
Anxiety/Depression/Mood Disorder		Testing
PTSD		

**Patient Diagnosis and Symptoms:**

Patient Diagnosis:	Presenting Symptoms/Comments:
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1610 Alice Street. Waycross, GA 31501  
108c Anderson Way, Brunswick, GA 31520  
tel: (912) 285-1610 fax: (912) 285-2595  
info@eupatheiacenter.com  
www.eupatheiacenter.com

**Insurance**

Carrier:	Policy Number:
Secondary	Secondary Policy Number:

***Office Use Only:***

**Appointment with The Eupatheia Center:**

*Date:*

*Time:*

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