Wellspring Center, PLLC
1995 NC Hwy 172 Suite B
Sneads Ferry, NC 28460
Phone: 910-327-0800
Fax: 888-728-0060

Physician Referral for Outpatient Services

Patient's Name: ____ DOB: ____________

Physician's Name: ____ NPI: _____________

Physician's Address: ____

Physician's Telephone: (_____)______________________ Fax: (_____)______________________

I, Dr. ________________________, wish to refer the above-named patient to Alicia L. Chinlund, MA, LPC, LPA,, for psychological services.

Physician's recommendations and/or observations (if applicable): ____________________________

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Medications (if applicable): ____

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I would like to be contacted in the following ways (check all that apply):

- ☐ No follow-up requested
- ☐ Summary letter (diagnosis and treatment plan)
- ☐ Periodic phone calls (progress reports)
- ☐ Communicate only critical medical needs
- ☐ Report non-compliance with treatment
- ☐ Other: ____

Physician's Signature: ____ Date: ____________

Alicia L. Chinlund, MA, LCMHC, LPA
Psychologist & Licensed Clinical Mental Health Counselor
Certified Health Services Provider
achinlund@wellspringcenterllc.com