R.E.A.L. Counseling, LLC.
Referral Form

Please complete this referral form and send back to us via fax or email! We will typically follow up with client within 24 hours.

FAX: 843.273.0075

EMAIL: info@realcounselingllc.com

Date of Referral: ____

Client Name: ____

If minor, parent/guardian name: ________________________________

Date of Birth: ____________ **Age:** ___________ **Sex:** _____________

Phone Number: ____

Email Address (If authorized): _________________________________

Preference of Office Location:

__ Myrtle Beach (Hwy 707) or __ North Myrtle Beach (Cherry Grove Area)

Insurance Type: _____________ **Referring MD/Office:** _______________

Your Fax Number: _______________ **Contact Name:** _________________

Brief description of reason for counseling referral:

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~Thank you for the referral~