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 child, parent/guardian name: _____

Age: _____ **Date of Birth:** _____ **Sex:**_____

Preference of office location:
___**Myrtle Beach (707) or** ___**N. Myrtle Beach (Cherry Grove section)**

Insurance Type: _____ **(Most insurance accepted)**

This client has been referred by: _____
(MD name/office/facility)

Your fax number: _____**Contact name:**_____

Brief description of reason for counseling referral: _____
_____
_____
_____
_____
_____
_____

~Thank you for the referral ~