Autumn Skye Counseling, PLLC

Vickie J. Kulinski, LCSW

Behavioral Health Referral Form

305 E. Union St., Unit B115 • Morganton, NC 28655 Phone: 303-847-7042

AUTUMN SKYE
COUNSELING, PLLC

Date:

Referring Provider:
Practice:
Phone: Fax:
Contact:

Patient Name: Insurance:
DOB: Member ID:
Phone: (or attach copy of card)
Address:

Reason for Referral (check all that apply):
☐ Anxiety ☐ Depression ☐ Trauma/PTSD ☐ Grief/Loss ☐ Stress ☐ Relationship Concerns ☐ ADHD
☐ Family Conflict ☐ New diagnosis or struggling with managing current diagnosis ☐ Mood Disorder
☐ Substance Use ☐ Life Transitions ☐ Other:

Clinical Concerns/Goals of Treatment:

Medical Diagnosis:

Psychiatric Diagnosis (if known):
*Please attach medication list

Safety Concerns: ☐ None Known ☐ Suicidal Ideation ☐ Substance Abuse (Current overuse or history)
☐ Self-Harm ☐ Homicidal Ideation ☐ Psychosis ☐ Other
Referral Priority: ☐ Routine ☐ Soon ☐ Urgent (please call)
☐ Patient has been informed of this referral and agrees to be contacted by phone.

Additional Notes:

Please fax completed referral to: **720-458-5097**
You may also give the patient my contact information and encourage them to reach out to me.
This form is not for psychiatric emergencies. Call 911 or send the patient to the nearest ED if immediate risk is present.