Referral Form

The Gift of Peace Counseling & Wellness, PLLC

P: (980) 216-6978
E: admin@thegiftofpeace.org

Referring Provider/Agency: _____
Referral Contact Number: _____
Email: _____

Referred Client Name: _____

Referred Client Address: _____

Referred Client Number: _____

Referred Client Email Address: _____

DOB _____ Age _____ Gender _____

Insurance type/ ID#: _____

Purpose of referral (type of counseling being sought, medication regimen, mental health treatment history, etc)?

_____
_____
_____
_____
_____
_____

Please email completed referral form to admin@thegiftofpeace.org

Kaiane Thompson, LCSW, LISW-CP
Owner, Clinical Therapist