Atlas Concepts, LLC
Referral Form

*If there is a risk of harm to self/others please contact local emergency services.
*Atlas Concepts is currently providing telemental health services (audio/video).

Referral Information:

Date ____________________
Referrer Name ____________________
Referring Agency ____________________
Phone Number ____________________ Fax Number ____________________
Email Address ____________________
If the referring agency requests updates on treatment, please describe.
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Client Information:

Client Name ____________________
Client Birthdate ____________________ Client Age ____________________
Phone Number ____________________
Email Address ____________________
Street Address ____________________
City ____________________
State ____________________ Zip Code ____________________

Insurance:

Primary Insurer ____________________
Primary Insurer Phone Number ____________________
Primary Insurance ID Number ____________________

Secondary Insurer ____________________
Secondary Insurer Phone Number ____________________
Secondary Insurance ID Number ____________________

Reason for Referral: ____________________
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Requested Services:

☐ Mental Health Assessment ☐ Other
☐ Therapy/Counseling ☐ Provider Discretion

Any other notes: ____________________
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Last Updated: 12/22/2023

Phone: (803) 681-0778
info@atlasconcepts.net