WHITE OAK Counseling and Recovery
4695 N M37 Hwy, Suite A, Middleville, MI 49333
phone: 269-205-2402 ◆ fax: 269-205-2728
e-mail: info@wocounseling-recovery.com ◆ website: wocounseling-recovery.com

Physician Referral FAX Form

Diagnosis: ____

Patient Name: ______________________________ DOB: ____/____/______

Contact Phone: (______) ________ - ____________

Request for Individual Therapy

☐ Evaluation and/or ☐ Treatment

Prescribed Duration/Intensity (if applicable): _______ weeks for _______ weeks/sessions

Concerns: ____

Request for Couples Therapy

☐ Evaluation and/or ☐ Treatment

Prescribed Duration/Intensity (if applicable): _______ weeks for _______ weeks/sessions

Concerns: ____

Request for Family & Group Therapy

☐ Evaluation and/or ☐ Treatment

Prescribed Duration/Intensity (if applicable): _______ weeks for _______ weeks/sessions

Concerns: ____

Request for Spaced Retrieval Therapy

☐ Evaluation and/or ☐ Treatment

Prescribed Duration/Intensity (if applicable): _______ weeks for _______ weeks/sessions

Concerns: ____

Request for EMDR Therapy

☐ Evaluation and/or ☐ Treatment

Prescribed Duration/Intensity (if applicable): _______ weeks for _______ weeks/sessions

Concerns: ____

______________________________ from ______________________________
Physician's/Provider's Printed Name — Name of Facility

______________________________ ____/____/______
Physician's/Provider's Signature — Date