The Center for Cognitive and Behavioral Therapy

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Kevin D. Arnold, PhD, ABBP
Director

Physician referral form for Mental Health Services or Psychological Testing

Date______________________

Referring Physician Name:____

Physicians Address:____

Fax: (____)____________________________ Phone: (____)_____________________________

Patient Name:

____________________________________Date of Birth:______________________________

Parent's Name:________________________ Patient's Phone: __________________________

Reason for Referral:

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Thank you for evaluating this patient. To facilitate communication and treatment, please fax this completed form to CCBT. CCBT will contact the patient and fax this back with notes regarding the appointment date. The patient will be contacted once a week for 3 weeks if they are non-responsive. You will get a fax back regardless of the results.

- ☐ Patient made appointment ___/___/___
- ☐ Patient did not want appointment
- ☐ Patient was attempted to be contacted on ___/___/___, ___/___/___ & ___/___/___