



Referral Department
Phone: (304) 513-3513
Fax: (304) 513-3519

Therapy: 1520 Kanawha Blvd. East Charleston, WV 25311

Medication Management: 100 Peyton Way, Suite 200 South Charleston, WV 25309

Therapy Providers

Cathy Rasnake, MA, LPC, AADC, MAC, EMDR Therapist
Monica McMillian, M.A., Licensed Psychologist
Nikki Erwin, LPC
Melinda Himstedt, LICSW
Nancy Longworth, LICSW

Medication Management Providers

Kiran Devaraj, MD - Medical Director
Megan Kister, APRN-PMHNP-BC
Kara Myers, APRN, PMHNP-BC, CNP
Juliana Rollo, APRN, FNP-BC

New Patient Referral

Referral Source Information:

Referring Provider/Source: _____

Ph: _____ Fax: _____

Client Information:

Client Name: _____

Date of Birth : ____/____/____ Age:____ ☐ Male ☐ Female

Legal Guardian (if applicable): _____

Address: _____

City: _____ State: _____ Zip: _____

Mobile Ph: _____ Home Ph: _____ email: _____

Insurance Information:

PLEASE COMPLETE THIS SECTION ENTIRELY

Primary Insurance: _____ ID #: _____

Name of Policyholder: _____ Date of Birth: _____

Relationship to Client:: _____ SS# of policyholder: _____

Employer: _____

Secondary Insurance: _____ ID #: _____

Name of Policyholder: _____ Date of Birth: _____

Relationship to Client:: _____ SS# of policyholder: _____

Employer: _____

Reason for Referral:

☐ **Medication Management**

(medication provided by a medical provider)

☐ **Psychotherapy**

(individual therapy/no medication)

Has the client previously received mental health services from a psychiatrist, psychologist, or therapist? ☐ Yes ☐ No

Provider & Dates: _____

Current Symptoms: _____

Current Medications: _____

PLEASE FAX COMPLETED REFERRAL TO 304-513-3519



Referral Department
Phone: (304) 513-3513
Fax: (304) 513-3519

Therapy: 1520 Kanawha Blvd. East Charleston, WV 25311

Medication Management: 100 Peyton Way, Suite 200 South Charleston, WV 25309

PLEASE FAX COMPLETED REFERRAL TO 304-513-3519