



Referral Department  
Phone: (304) 513-3588  
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, EMDRIA  
Monica McMillian, M.A., Licensed Psychologist  
Nikki Erwin, LPC  
Melinda Himstedt, LICSW  
Nancy Longworth, MSW, LICSW, MAC, EMDRIA  
Rebecca Bowman, MSW, 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

Psychotherapy

Psychological Testing

(medication provided by a medical provider)

(therapy only/no medication)

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

Provider & Dates: \_\_\_\_\_

Current Symptoms: \_\_\_\_\_

**PLEASE FAX COMPLETED REFERRAL TO 304-513-3519**