Melissa Thingvoll MD PLLC
100 District Ave, Suite 218
Asheville NC 28803
Phone: (828)774-5068 FAX: (828)575-5448

Referral/Consultation Form (To Be Completed by Physician)

Demographic Information

Child's Name: Last_____ First_____ ☐Male ☐Female
Date of Birth _____/_____/_____
Address _____
City _____ State _____ Zip_____

Parent Info

Mother/Legal Guardian
Name _____ Email Address _____
Address (If Different Than Above) _____
City _____ State _____ Zip _____
Home Phone _____ Cell Phone _____

Father/Legal Guardian
Name _____ Email Address _____
Address (If Different Than Above) _____
City _____ State _____ Zip _____
Home Phone _____ Cell Phone _____

Insurance Info

Primary Insurance Type _____
Primary Policy Holder_____ DOB ___/___/___
Insurance ID Number _____ Group Number _____

Referral Concerns

Referring Physician or Provider_____
Practice Name_____
Practice Address _____
City _____ State _____ Zip_____
Phone_____ FAX_____

Reason for referral_____
_____
_____
_____
_____

Has this child taken any medications in the past for behavioral or developmental concerns? ☐Yes ☐No
If yes, please list medications, reason for taking and any positive or negative response_____
_____
_____
_____
_____

Please FAX any pertinent records along with this completed form to (828)575-5448