Version 10-15

_____ Therapist Initials Today's Date: _____

DUKE INTEGRATIVE MEDICINE
PSYCHOLOGY REFERRAL FORM

Please send completed form to Julie Seel, Ph.D.
Email: Julie.Seel@dm.duke.edu
Fax: (919) 681-0380
Duke Integrative Medicine
3475 Erwin Rd.,
Durham, NC 27705

Upon receipt of this form, a therapist will call to discuss our process and to determine whether we are a good fit for your needs. If you are not contacted within two business days or would like additional information, please call Julie Seel, Ph.D. at (919) 684-9843. Thank you!

CLIENT INFORMATION

Name: _____ Date of Birth: _____

Gender: _____ Duke Medical Record Number (MRN): _____

Phone: _____ May we leave a message? YES NO

Email: _____ May we email you? YES NO

Mailing Address: _____

Insurance Provider: _____ Policy Number: _____

How did you hear about our psychology services? _____

Do you have a strong preference for a male or female provider? If yes, which do you prefer? _____

_____

Please *briefly* describe your reason(s) for seeking treatment. Check here ☐ if you prefer to discuss only with your therapist: _____

_____

_____

_____