

Referral Form

117 Commons Way Greenville, SC 29611
Tel: (864) 520-2020 Fax: (864) 640-4400
Email: referrals@itrustwellnessgroup.com

Name of Referring Provider:	
Referring Provider Specialty:	
Practice Address:	
Office Telephone No:	
Office Fax No:	

Full Name of Patient:	
Date of Birth:	
Home Address:	
Telephone Number:	
Reason for Referral	
Relevant medical history:	
Patient's primary/secondary insurance provider(s). Please provide member's ID if it is not included in a faxed chart accompanying this page:	

Please fax completed form to (864) 640-4400 or email Ashley@itrustwellnessgroup.com . Our providers will make every effort to respond to referral requests as soon as possible.

[OR A REFERRAL CAN BE SUBMITTED BY FAMILY MEMEBERS AND CAREGIVERS THROUGH OUR WEBSITE]

1. Go to iTrustWellnessGroup.com

2. Click on Elderly Care Referral Form



Mental health affects all ages.

Elderly care can be one of the most delicate situations for families to navigate through, for both the individual and their loved ones. As mental health symptoms arise, it can begin to feel overwhelming. Co-occurring diagnoses can often obscure other underlying issues, making it difficult to see a mental health diagnosis.

This page is specifically intended for assisted living facilities that we have already established a partnership with. If you or your assisted living team desire to learn more about psychiatric care for your residents, please do not hesitate to call us at 864-520-2020 or email ashley@itrustwellnessgroup.com to discuss this coordination.

3. All information and insurance info can be completed on this one form.



Elderly Care Referral Form

Demographic Information

Name of Client*

First Last

Client's Date of Birth*

MM/DD/YYYY

Client's Social Security Number:

Assisted Living/Care Facility Client Resides in*

The Pearl at Eastside

Name of Power of Attorney/Other Person Providing Consent for Treatment*

First Last

Consent to Treatment*