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FACSIMILE TRANSMITTAL

To: Aspire Counseling Group, PLLC	Fax: 919.747.4269
From:	Date:
Subject:	Pages:

Client name		
Name of Person making referral		
Reason referred?		
*Client told to contact Aspire to make appointment?	Yes	No
Would the referral source like to receive a follow-up call from the therapist about the client?	Yes	No

***Aspire will only contact the client to make an appointment in special circumstances*. Otherwise, clients should call Aspire to make an appointment. If there are special circumstances making it necessary for Aspire to initiate contact, indicate those circumstances here:**

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