CHOOSING Her Wellness Center

Therapy Referral Form

Serving clients in Massachusetts (MA) & Rhode Island (RI)
150 Grossman Drive Suite 205, Braintree, MA 02184
Ph: (401) 405-1104 | carlene.mcnair@choosingherwellness.com | www.choosingherwellnesscenter.com

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Referral Source Information

Date of Referral: _____
Referring Provider/Agency: _____
Contact Name: _____
Phone: _____
Fax: _____
Email: _____
Relationship to Client: ☐ PCP ☐ Psychiatrist ☐ Family ☐ Other: _____

Client Information

Full Legal Name: _____
Date of Birth: ____ / ____ / _____
Gender: ☐ Male ☐ Female ☐ Non-Binary ☐ Prefer Not to Say ☐ Other: _____
Address: _____
City/State/ZIP: _____
Phone: _____
Email: _____
Client's Preferred Contact Method: ☐ Phone call ☐ Email
Client's Preferred Language: _____
Any Special Accommodations Needed? _____

CHOOSING Her Wellness Center

Insurance & Payment Information

Insurance Provider: _____
Member ID #: _____
Group #: _____
Subscriber Name & DOB (if not client): _____
Relationship to Client: _____
Self-Pay? ☐ Yes ☐ No

Reason for Referral

(Please check all that apply or describe in detail below)

☐ Anxiety
☐ Depression
☐ Trauma/PTSD
☐ Bipolar Disorder
☐ Perinatal Mood and Anxiety Disorders (PMADs)
☐ Grief/Loss
☐ Family Conflict
☐ Substance Use
☐ Behavioral Issues
☐ Relationship Issues
☐ Life Transitions
☐ Posptartum Support
☐ Other: _____

Brief Description of Concerns:

_____
_____
_____
_____
_____

Urgency of Referral: ☐ Routine ☐ Moderate ☐ Urgent

Is the client currently at risk to self or others? ☐ Yes ☐ No

If yes, please provide safety details: _____

_____

_____

_____

_____

_____

_____

Please note, CHOOSING Her Wellness Center is not a crisis center. If the individual you are referring is experiencing a mental health emergency or needs a higher level of care, please contact emergency services or direct them to the nearest crisis resource.

Does the client have any past substance use? ☐ Yes ☐ No

Does the client have any current substance use? ☐ Yes ☐ No

If yes, please provide details:

_____

_____

_____

_____

Is the client currently pregnant? ☐ Yes ☐ No

Services Requested

Please note, at this time we are only offering individual telehealth therapy to adults.

☐ Individual Therapy

☐ Couples/Marriage Counseling

☐ Family Therapy

☐ Child/Adolescent Therapy

☐ Psychological Assessment

☐ Telehealth

☐ In-Person (location dependent)

☐ Other: _____

Additional Information

Has the client received outpatient therapy in the past? ☐ Yes ☐ No
Does the client have a history of inpatient psychiatric hospitalization? ☐ Yes ☐ No
If yes, please provide the dates and reason for psychiatric hospitalization:

_____
_____
_____
_____

Is this client being discharged from inpatient psychiatric hospitalization? ☐ Yes ☐ No

Is the discharge paperwork attached: ☐ Yes ☐ No

Please list current medications and prescriber information:

_____
_____
_____
_____
_____

Mental Health
Diagnoses_____:_____
_____
_____
_____
_____

Release of Information

☐ A signed Release of Information (ROI) is attached
☐ ROI **needed** from client prior to contact

Please return this form by email to carlene.mcnair@choosingherwellness.com (encrypted if possible).
For questions, contact us at (401) 405-1104.
Thank you for your referral. We will follow up with the client or referring provider within 2–5 business days.