

HOPE



Psychotherapy Services, LLC
Helping Others Pursue Excellence

REFERRAL SOURCE

Name: _____ Agency: _____
Address: _____ Phone: _____
Fax: _____ E-Mail: _____

Summarize the Reason for Referral (Why did you call today?)

Screening Recommendation: (based on information provided, what service seems most appropriate?)

Op Services

CLIENT INFORMATION

(TO SEARCH MEDICAID ELIGIBILITY WE NEED EITHER MEDICAID NUMBER OR DATE OF BIRTH AND SS NUMBER)

Client's Name: _____ Medicaid #: _____
Address: _____
Home Phone: _____ Alternate Phone: _____
DOB: _____ Provider 1 _____ MCO: _____ Age: _____ Gender: _____
Provider ID: _____

Father's Name: _____ Address: _____
Cell Phone: _____ Home Phone: _____ Alt. Phone: _____

Mother's Name: _____ Address: _____
Cell Phone: _____ Home Phone: _____ Alt. Phone: _____

Guardian's Name: _____ Address: _____
Cell Phone: _____ Home Phone: _____ Alt. Phone: _____

Cell Phone: _____ Home Phone: _____ Alt. Phone: _____