REFERRAL FORM

Please complete the following and send this form, and any additional information to: lakesha@lsjcounselingandclinical.com or fax to 866-800-2456.

LSJ Counseling & Clinical Services

DEMOGRAPHICS

Client Name:

Client Address:

City/State/Zip:

Date of Birth/Age:

Insurance Type: Policy Number:

Phone Number(s): Caretaker name:

Referring Person/ Agency

Phone Number: _____ Email: _____

REQUESTED SERVICES (Mark all that apply)

Child Adult

Services Requested (assessment required; services based on medical necessity and as authorized by payment source)

REASON FOR SEEKING SERVICES

Concerns:

Symptoms/Behaviors/Issues at Home:

Symptoms/Behaviors/Issues at School/Employment:

Symptoms/Behaviors/Issues in the Community:

Please attach any relevant information you might think is necessary.