REFERRAL FOR SERVICES

|  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- |
| DATE: | | | Wednesday, January 10, 2018 | | | | | | | | | | | | |
|  | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| REFFERING PERSON/PROFESSIONAL | | | | | | | | | | | | | | | | |  | | | | | | | | | | | | | | | | | | | | | | | | |
| Phone: | | | | |  | | | | | | | Address: | | | | | |  | | | | | | | | | | | | | | | | | | | | | | | | |
| Fax: | | | | |  | | | | | | | Email: | | | | | |  | | | | | | | | | | | | | | | | | | | | | | | | |
|  | | | | | | | | | |  | | | | | | | | |  | | | | | | | | | | | | | | |  |  | | | | | | | |
| CLIENT NAME: | | | | | | | | |  | | | | | | | | | | | | | | | | | | D.O.B. | | |  | | | | | | | | | | | |
| SSN#: | | | |  | | | | | | | Medicaid# | | |  | | | | | | | | | | | | | |  | | | | | | | | | |
| Gender: | | | |  | | | | | | | Ethnicity: | | |  | | | | | | | | | | | | | Race: | |  | | | | | | |
| Address: | | | |  | | | | | | | | | | | | | | | | | | | | | | Contact Phone# | | | | | |  | | | | | |
|  | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| PARENT/GUARDIAN: | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| Address: | | | |  | | | | | | | | | | | | | | | | | | | | | | Contact Phone# | | | | | |  | | |  | |
|  | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| REASON(S) FOR REFERRAL | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
|  | Assessment (Type:     ) | | | | | | | | | | | | | | | | | |  | | | Individual Therapy | | | | | | | | | |  | Family Therapy | | | | | | | | |
|  | | TF-CBT | | | |  | | Sex. Behav. Issue | | | | |  | | Behavioral | | | | | | | | |  | Other *Describe* (     ) | | | | | | | | | | | | | | | | | |
| BRIEF DESCRIPTION OF PROBLEM (*Please fax/email any supporting or historical documentation)* | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
|  | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| BILLING INFO: | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| Primary Insurance Company *(non-Medicaid Insurance)*: | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| Policy# | | | | | | | | | | | | | | | | | | | | | Phone: | | | | | |  | | | | | | | | | | | | | | | | |
| Name of Insured: | | | | | | |  | | | | | | | | | | | | | | | D.O.B. of Insured: | | | | | | | | |  | | | | | | | | | | | |

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ 1/10/2018 9:54:43 PM

Referring L.I.P./Professional / Person Signature Date & Time