REFERRAL FOR SERVICES

|  |  |
| --- | --- |
| DATE: | Sunday, January 26, 2020 |
|  |
| 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: |       |

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