Integrity Counseling LLC - Referral Form

Please Fax or send via secure email:

Fax: 1-866-327-3295

Email: office@integritycounselingllc.net

Office Phone Number: (920) 385-1420

Website: www.integritycounselingllc.net

Date of Referral

Provider Making Referral

Provider Name:

Providers Organization:

Provider E-mail:

Provider Phone Number:

Have you spoken to someone in our office about this referral? If so, who did you talk to and when? What was decided as a result of this conversation?

Therapist Being Requested:

Therapist Name

Office Location Being Requested:

Client Name:

Client DOB:

Client Gender ◯ Male ◯ Female

Name of Insurance Client is covered by:

Member ID #

Name of Insured:

DOB of insured:

Brief Description of the Problem or Reason for the referral

Name of Person to contact to schedule appointment and relationship to client:

Contact Phone #:

Urgency Level:

Client AVAILABILITY:

Preferred time for service:

- ☐ between 8 AM and 12 PM
- ☐ between 1 PM and 4 PM
- ☐ between 5 PM and 8 PM
- ☐ Weekends Preferred
- ☐ Other

Thank you for your referral. The client will be contacted within 48 hours to have an appointment scheduled.

Please be sure to fax over any client information or records regarding this client.
FAX #: (866) 327-3295