Date of Referral: _____

Auth Completed: _____

First Appt. Scheduled: _____

With: _____

Wait List (?): _____

Follow-Up: _____

_____

_____

The Western Maryland Counseling Center, Inc.

Referral Form

Office Preference: *Hagerstown* ☐ *or* *Frederick* ☐

Name of Client: _____ **Guardian:** _____

Date of Birth: _____

Social Security #: _____

Current Address: _____

Phone Number: _____ **message okay?** ☐ **Yes** ☐ **No**

Email: _____

Self-Pay ☐ **or:** **Medicaid** ☐

Medicaid ID#: _____

** **We are not yet accepting Private Insurance at either the Frederick or Hagerstown locations**

Presenting Issues:

_____

_____

Referring Agency: _____

Person Making Referral/Phone #: _____

Hagerstown Office:
322 E. Antietam St., Suite 101
Hagerstown, MD 21740
WMCC201a@gmail.com
Phone: 301-733-2431
Fax: 301-733-2432

Frederick Office:
359 W. Patrick St.,
Frederick, MD 21701
WMCCinFrederick@gmail.com
Phone: 240-257-6830
Fax: 240-745-3950