Referral to Live Life Counseling

Today’s Date:

Patient Name: Date of Birth:

Guardian Name (if applicable): Relationship to Patient:

Contact Number: Email:

Address: City:

State: Zip:

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Insurance Information Primary: Member ID:

Subscriber Name: Relationship to Patient:

(Live Life accepts: Aetna, Amerigroup, Blue Cross Blue Shield, CareSource, Peachstate, and Wellcare)

Are you using the School Mental Health Grant - **yes or no** – if yes, which school does the child attend\_\_\_\_\_\_\_\_\_\_\_\_ List amount paid by grant and amount paid by client \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

This has been approved by Forsyth County Schools – **yes or no**

Referral Contact Person: Contact Number:

Facility Name:

Address: City:

State: Zip:

E-mail:

Current Challenges:

Please Select One:

 \_\_ Contact Patient To Schedule Appointment \_\_ Patient Will Contact Your Office