REFERRAL INFORMATION

Date of Referral: ____ / ____ / ____

Referred By: _____

Reason for Referral: ____ Mental Health Services ____ Substance Abuse Services

Is there an existing Mental Health and/or Substance Abuse diagnosis? ____ Yes ____ No

If so, please list all diagnoses: _____

_____

Referrer Contact Information:

Phone: _____ Email: _____

CLIENT INFORMATION

Client Name:

Last: _____ First: _____ MI: _____

Date of Birth: ____ / ____ / ____ Sex: Male Female Social Security #: _____

INSURANCE INFORMATION

Primary Insurance Company: _____

ID Policy #: _____ Group #: _____

Claims Address:

_____

Phone #: _____

Policy Holder's Name:

Last: _____ First: _____ MI: _____

Date of Birth: ____ / ____ / ____ Sex: Male Female Social Security #: _____

Phone #: _____ Social Security #: _____

Effective Date of Insurance: ____ / ____ / ____

Patient Relationship to Insured: Self Spouse Child

*Please fax all referrals to 980-218-9728 (do **NOT** email).*

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