

## Referral Information

Date: \_\_\_\_\_  
Name of person making referral: \_\_\_\_\_  
Relation to client: \_\_\_\_\_  
Address: \_\_\_\_\_  
Phone: \_\_\_\_\_  
Best times to call: \_\_\_\_\_  
Can we leave a message? Y or N

### Client Information

Full Name: \_\_\_\_\_  
Date of Birth: \_\_\_\_\_ Age: \_\_\_\_\_ M or F  
Address: \_\_\_\_\_  
Phone: \_\_\_\_\_ Can we leave a message? Y or N  
Best times to call: \_\_\_\_\_

### Referral source

Hospital  Therapist  
 Psychiatrist  Family Member  
 Self-referred  School  
 Other, please describe: \_\_\_\_\_

### Concerns

Suicidal thinking/behavior  
 Self-harming behavior  
 Psychiatric Hospitalization with the last year: Dates \_\_\_\_\_  
 Alcohol and drug issues  
 Eating Disorder behavior  
 Other: \_\_\_\_\_

**Client availability for treatment:** Days \_\_\_\_\_ Times: \_\_\_\_\_

**Client Insurance:** Carrier: \_\_\_\_\_

ID#	Group#	Customer Service #	
In network:	# used	Renewal date	Copay
Session #			Deductible
Out-of-network:	# used	Renewal date	Copay
Session #			Deductible
Pre-authorization required?		Y or N	Pre-authorization #