**Referral: Outpatient Therapy**

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**Client Information:**

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| Client’s Name:  |
| DOB:  | SSN: |
| Pronouns:  | Gender Identity: | Sex: |
| Address: |
| Phone number:  | E-mail: |

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| Primary Contact Person/Guardian (if different from above): |
| Relationship: |
| Address: |
| Phone number:  | E-mail: |

**Insurance Information:**

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| Medicaid: | Private Insurance: | Other : |
| Medicaid # (if applicable): |
| Name of Insurance: |
| Member/ID #:  |
| Secondary Insurance (if applicable): |
| If Other, what is the payment source: |

**Please write a brief description of the need for treatment or reason for referral:**

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**Referral Source:** \_\_ Self \_\_Other:

If other please add:

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| --- |
| Name: |
| Address: |
| Phone Number: | E-mail |