**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: | |

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

**Insurance Information:**

|  |  |  |
| --- | --- | --- |
| 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:

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