REFERRAL FOR MENTAL HEALTH SERVICE

Thank you for your referral. Healing Path will contact you to confirm that the referral has been received. Please discuss the nature and intent of this referral with your client. We will contact the client to schedule an appointment.

Referral Date: ______________ Referral Contact Phone: ______________ Referral Fax: _______________

Referral Source (Name and Agency): ______________________ Referral Email: _____________________

Referral Address: ____

Client Name: ___________________________________ DOB: _______________ Gender: __________

Client Address: ____

Contact Phone: _______________ Does client need interpreter: ___________ Language: ________________

Insurance (List primary and secondary) *(include copy of cards)*	**Policy #**	**Group #**
________________________________	_________________	________________________________
________________________________	_________________	________________________________

Release of Information:

________ A signed/dated consent for release of information is attached to this referral (required).

Please indicate services requested:

________ **Outpatient Therapy**
________ **Posttraumatic Stress Disorder**
________ **Diagnostic Assessment**
________ **Family Therapy**
________ **DBT (Dialectical Behavior Therapy**
________ **Diagnostic Assessment**
________ **Psychological Evaluation**
________ **Education/Medication Management**

Describe reason for referral:

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Name of person referring: ___________________________ **Date:** ___________________