Outpatient Treatment Referral Form

Please submit this form along with any other necessary documentation or releases of information. If you wish to fax, please include a cover sheet and send to **(833) 373-0348**

Referral Source:____ Date:______________________

Phone Number: ________________________

Provider Information

Name:_______________________________ Phone: _____________________________

E-Mail_______________________________ Fax:______________________________

Client Demographics

Name:_________________________________ Date of Birth:__________________________

Address:____

Insurance Provider:___________________________ Policy ID:____________________________

Phone Number:________________________ E-mail:____________________________________

Is client a Minor: □ Yes □ No

Guardian Contact Information: ____

Guardian's Relationship to Client:____

Reason for Referral: ____

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Potential Risk Factors

□ Current Suicidal Ideation/Behavior

□ History of Suicidal Ideation/Behavior

□ History of Trauma

□ History of Violent Behavior

□ History of Abuse

□ Other:____

Co-occurring Illnessess:____

____

Current Medications (Please include dosage and frequency):______________________________

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