REFERRAL FORM

DATE: _____ **START DATE:** _____ **PSYCHOTHERAPIST:** _____

REFERRAL SOURCE (AGENCY/PERSON) _____

CLIENT'S NAME _____ DOB: _____

CLIENT ADDRESS: _____ CLIENT PHONE: _____

CLIENT EMAIL ADDRESS: _____

SOC. SEC. # _____ GENDER: _____ AGE _____ RACE _____ ETHNICITY _____

PARENT/GUARDIAN/OTHER: _____

HOME PHONE: (_____) _____ WORK HOME: (_____) _____

EMERGENCY CONTACT: _____

HOME PHONE: (_____) _____ WORK HOME: (_____) _____

Courage Consulting & Counseling for the individual or family (CCCIF), LLC
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courageconsultingandcounseling.com | Phone: 651-440-5091 | Email:starla@courageconsultingandcounseling.com

REASON(S) FOR REFERRAL (CHECK ALL THAT APPLY)

☐ INDIVIDUAL THERAPY ☐ FAMILY THERAPY ☐ GROUP THERAPY ☐ CO-OCCURRING

PROBLEM AREA:

_____

_____

_____

_____

_____

_____

INSURANCE INFORMATION

PRIMARY INSURANCE COMPANY _____

POLICY # _____ AUTHORIZATION # _____ PHONE (_____) _____

NAME OF INSURED _____ MEDICAID # _____

SECONDARY INSURANCE INFORMATION

INSURANCE COMPANY _____

POLICY # _____ AUTHORIZATION # _____ PHONE (_____) _____

NAME OF INSURED _____ MEDICAID # _____