

REFERRAL REQUEST

Today's Date: _____

Client's Name: _____ DOB: _____

Client Phone: _____ Insurance Carrier: _____

Name of Person submitting request: _____ Phone: _____

Provider's Name: _____

Phone (if different than above): _____ Fax: _____

Please include a copy of a Release of Information

Primary Mental Health Diagnosis: _____

First Appt/Admit Date _____ Discharge Date _____ Tx Ongoing ____

Are you a DHS Caseworker? _____

Service Reqst'd

Recommended number of sessions per week/Add'l info

_____ Family Therapy	_____
_____ Individual Therapy	_____
_____ Group Therapy	_____
_____ Day Treatment	_____

ADDITIONAL COMMENTS:

For follow up choose from the following options:

- Weekly Updates**
 - Update after each session**
 - Periodic at your discretion**
 - Include me in team meetings as needed**
- Provider Contact info: (Phone)** _____

Confidentiality Note:

This fax is confidential/legally privileged, and is intended for the providers named on this form. If you are not listed on this fax, you are hereby notified that you have received this in error and that any review, disclosure, dissemination, distribution or copying of it is prohibited. Please notify the sender and destroy the fax received.

FAX THIS REQUEST TO 503.263.6278