SMPsychotherapy & Counseling Services, LLC

PRIVATE THERAPY REFERRAL FORM

Date:_____ Referral Source:_____

CLIENT INFORMATION:

Client Name: _____ Guardian(s): _____

Date of Birth: _____ Age: _____ Marital Status:_____ Social Security Number: _____

Home Address: _____

City: _____ State: _____ Zip: _____

Home Phone: _____ Cell Phone: _____ _ Business Phone: _____

Employment Status- FT /PT /Ret /Un . Employer:_____

Personal Physician & Phone Number:_____

Prescribing Psychiatrist & Phone Number:_____

Name of Attending School: _____ Grade:_____

School Address & Contact: _____

HEALTH INSURANCE CARRIER:

Name of Insurance Plan or Program: _____

Policy Number: _____ Group Number_____

Policyholder (self, spouse, parent, etc.): _____DOB:_____

Policyholder's Address:_____

Additional health insurance _____

Deductible:_____ Copay:_____

PRESENTING PROBLEM: _____

_____

Current/Past Providers: _____

Prescribed Medications: _____

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