Wagner Behavioral Health Services, LLC

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www.wbhservices.com

ADOLESCENT/ADULT

SOP EVALUATION/TREATMENT REFERRAL FORM

Date of Referral: _____

CLIENT INFORMATION:

First Name: _____ Middle Initial: _____ Last Name: _____

Address: _____ Date of Birth: _____ Age: _____

_____ Telephone: _____

Employed? ☐ Yes ☐ No Employer: _____

If Minor:

Parent/Guardian's Name(s): _____ Address: _____

Telephone Number: _____ Cell: _____ _____

To whom is the child/youth currently residing? _____ What is the relationship to the client? _____

Name of School: _____ Grade: _____

INSURANCE INFORMATION:

Name: _____ Policy/ID#: _____

Insurer's Name: _____ Insurer's Date of Birth: _____

**Payments/Co-pays/Co-Insurances must be made at each appointment.

REFERRAL SOURCE:

Referral Name: _____ Title: _____

Facility Name: _____

Address: _____ Telephone: _____

_____ Fax:: _____

REASON FOR REFERRAL:

Court Ordered? ☐ Yes or No ☐ When? _____ Charge(s)? _____

Judge: _____ Client's Attorney: _____ _____

Time Frame for the Evaluation: _____ Is it needed for court? ☐Yes *or* No ☐

Court Date? _____

Provide a brief reason for your referral.

_____

_____

NOTICE

To effectively complete Psycho/Sexual Evaluations with recommendations related to safety and/or treatment concerns, it is imperative that WBH Services is provided with any and all collateral information prior to meeting with the client. Information that is beneficial would include Court Orders, Affidavit of Probable Cause, Case Notes, School Records, Psychological Reports, available mental health or drug and alcohol records, Domestic Relations Records, Probation/Parole Documents, District Magistrate Records, relevant newspaper articles, and/or summaries of involvement with the referred client.