Wagner Behavioral Health Services, LLC

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ADOLESCENT/ADULT REFERRAL FORM

Outpatient Mental/Behavioral Health Services

Date of Referral: _____

CLIENT INFORMATION:

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

Address: _____ Date of Birth: _____

_____ Telephone: _____

Social Security Number: _____ Male ☐ Female ☐ Age: _____ Grade: _____

County: _____ Work/School: _____

(If minor)

Parent/Guardian's Name(s): _____

Relationship to client:: _____ Telephone: _____

To whom is the child/youth currently residing? _____

Address: _____

Telephone: _____ What is the relationship to the client? _____

INSURANCE INFORMATION:

Name: _____ Policy/Member ID#: _____

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

Insurer's Social Security Number: _____ Insurer's Telephone: _____

**If not accepted, will pay "out of pocket" ? ☐ Yes or No ☐ **Payments/Co-pays/Co-Insurances must be made at each appointment.

REFERRAL SOURCE:

Referral Name-*(Please Print)* _____ Title: _____

Facility Name: _____

Address: _____ Telephone: _____

_____ Fax: _____

REASON FOR REFERRAL:

Provide a brief outline of your concerns and clinical/medical history. Attach any pertinent information available.

_____

_____

_____

_____

_____

_____

Court Ordered? ☐ Yes or No ☐ When? _____ Charge? _____

Judge: _____ Client's Attorney: _____

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

NOTICE

To effectively complete Victims Evaluations with recommendations related to 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, Case Notes, School Records, Psychological Reports,