Wagner Behavioral Health Services, LLC

115 S. Washington St., Suite 202
Titusville, PA 16354
Tel./Fax: 814-827-2218
www.wbhservices.com

285 Hospital Drive, Rm. 315
Warren, PA 16365
Tel: 814-726-2100 ext 8473
Fax: 814-827-2218

NOP Support Group Referral Form

Date of Referral: _____

CLIENT INFORMATION:

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

Address: _____ Date of Birth: _____ Age: _____

_____ Telephone: _____

Employed? ☐ Yes ☐ No Employer: _____ Social Security No.: _____

Status: ☐ Single ☐ Married ☐ Divorced ☐ Separated ☐ Widowed ☐ Other Name: _____

Child(rens) Names:	Age:	Gender:	Check one that might describe each child:
_____	_____	_____	☐ Survivor of Abuse ☐ Offender ☐ Both ☐ None
_____	_____	_____	☐ Survivor of Abuse ☐ Offender ☐ Both ☐ None
_____	_____	_____	☐ Survivor of Abuse ☐ Offender ☐ Both ☐ None
_____	_____	_____	☐ Survivor of Abuse ☐ Offender ☐ Both ☐ None
_____	_____	_____	☐ Survivor of Abuse ☐ Offender ☐ Both ☐ None

**If there is more than 5 children , please write any additional children on the back of this form, Thank you.*

INSURANCE INFORMATION:

*If not insurance, please mark "NONE" on the line. Thank you.

Name: _____ Policy/ID#: _____

Insurer's Name: _____ Group #: _____

Social Security No.: _____ Insurer's Date of Birth: _____

REFERRAL SOURCE:

Referral Name: _____ Title: _____

Facility Name: _____

Address: _____ Telephone: _____

_____ Fax:: _____

REASON FOR REFERRAL:

Provide a brief reason for your referral.

_____

_____

_____

_____

_____

_____

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

Judge: _____

Client's Attorney: _____ Telephone: _____

Note: Processing May Be Delayed If Information Submitted is Illegible or Incomplete.

Fax: 814-827-2218 or

Mail: WBH Services, LLC, P.O. Box 35, Titusville, PA 16354-0035