Wagner Behavioral Health Services, LLC www.wbhservices.com
115 S. Washington Street (Main Office) Tel.: (814) 827-2218
P.O. Box 35, Titusville, PA 1634-0035 Fax: (814) 271-7262

CLIENT REFERRAL FORM

Today's Date: _____

CLIENT DEMOGRAPHIC INFORMATION:

Name: _____ Date of Birth: _____ S.S#: _____
First Middle Last

Address: _____ Work: ☐Full Time ☐Part Time ☐Disability ☐Unemployed ☐N/A

_____ Age: _____ School: _____ Grade: _____

Telephone:(____)_____ Leave Messages: ☐Yes ☐NO (____)_____ Leave Messages: ☐Yes ☐NO
Home Cell

Marital Status: ☐ Married ☐Single ☐Divorced ☐Separated ☐Widowed ☐Significant Other: _____

Name of Spouse/Other:(if applicable): _____Telephone:(____)_____ Leave Message?: ☐Y ☐N

If Minor:

Where does the child currently reside?: ☐ Both Parents ☐Mom ☐Dad ☐Other:_____

Parent/Guardian's Name _____ Relationship: _____

Current Address: _____Telephone No:_____

Parent/Guardian's Name _____ Relationship: _____

Current Address: _____Telephone No:_____

INSURANCE INFORMATION:

1. Type of Insurance: ☐No Insurance/Private Pay ☐Major Medical ☐Medicare ☐(MA) Medicaid/ACCESS ☐EAP ☐Other

Insurance Name: _____ Policy/Member ID: _____ Group #: _____

Primary Card Holder's Name: _____Date of Birth: _____ S.S.#: _____

Relationship to Primary Card Holder: ☐Self ☐Spouse ☐Child ☐Other

2. Type of Insurance: ☐No Insurance/Private Pay ☐Major Medical ☐Medicare ☐(MA) Medicaid/ACCESS ☐EAP ☐Other

Insurance Name: _____ Policy/Member ID: _____ Group #: _____

Primary Card Holder's Name: _____Date of Birth: _____ S.S.#: _____

Relationship to Primary Card Holder: ☐Self ☐Spouse ☐Child ☐Other

REFERRAL SOURCE:

Referred By: _____ Title: _____Telephone: _____

Facility/Office Name: _____ Address: _____

Email: _____ Fax: _____

REASON FOR REFERRAL:

Service(s) Requesting: ☐Individual ☐Family/Couple ☐Group ☐Evaluation(Specify):_____

If Evaluation, need by? _____ ☐Other _____

Preferred Location: ☐Titusville ☐ Warren ☐Franklin ☐Other: _____

Brief summary of your concerns:_____

_____

_____Continue on back if need →

If Evaluation, date needed by? _____ **Court Ordered?** ☐Y ☐N Court Date? _____ By Whom? _____

Previous behavioral/mental health treatment? ☐Yes ☐No? Where: _____

For What? _____ By Whom/Where?: _____

What was the diagnosis/out come? _____

↓For Office Use Only↓

First Appointment Date/Time: _____Therapist Assigned: _____ Interviewer's Initials: _____

Welcome Letter Sent?: ☐Yes ☐No When? _____ Forms Sent: ☐Demographic Info. ☐Adult/Child Checklist ☐Young Adult Information ☐Childhood Development History ☐Other: _____