OUTPATIENT THERAPY REFERRAL FORM

Date of Referral: ___________ **Office:** _______________ **Therapist Assigned:** ____________________________

Referral Source: __________________________________ **Phone:** ______________________________________

Patient Name: ____ **DOB:** ___________ **Age:** _____________

Address: ____

Phone Number: ________________________ **Alternate Phone Number:** ____________________

Ok to leave message: ☐Yes ☐No **Ok to leave message:** ☐Yes ☐No

Person to be contacted for appointments: _________________________________ **Phone:** ____________________

Service Requested: Individual Family Couples **Counselor Preference:** Male Female None

Presenting Issue: ____

Preference for Appointments: **Morning** **Afternoon** **Evening** **Other:** _______________________________

INSURANCE INFO
Insurance Carrier: _________________________ **Policy Number:** ______________________________________
(FPLIC, FPH, Highmark, and BCBS have a three letter prefix)

Secondary Insurance: ____________________________ **Policy Number:** __________________________________

Subscriber Name: _________________________________ **Subscriber DOB:** ______________________________

Subscriber Address: ____

Additional Comments: ____
Referrals can be faxed for the Scranton Office at 570.955.5528 and for the Harrisburg Office at 717.695.0853

10/15/17

CONFIDENTIAL