OUTPUTPATIENT 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 None Other: ________________________

Preference for Appointments: Telehealth Face-to-Face No Preference

INSURANCE INFO
Insurance Carrier: _________________________ **Policy Number:** ______________________________________

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

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

Subscriber Address: ____

Additional Comments: ____

Referrals can be faxed for the Scranton Office at 570.955.5528, 570.465.2081 for Elk Lake and New Milford, and for the Harrisburg Office at 717.695.0853

8/31/20

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