OUTPUTPATIENT THERAPY REFERRAL FORM

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

Referral Source: __________________________________ **Phone:** ______________________________________

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

Address: ____

Phone Number: **Ok to leave message:**

Alternate Phone Number: **Ok to leave message:**

Email address:

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

Service Requested: **Counselor Preference:**

Presenting Issue: ____

Preference for Appointments: Other: ________________________

Preference for Appointments:

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, Lackawanna College, North Pocono at 570.955.5528, 570.465.2081 for Elk Lake, Mountain View, and New Milford, and for the Harrisburg Office at 717.695.0853 and for the Elizabethville Office at 717.362.8910

8/6/22