Referral Form

Referral Date: ____________________________

Youth's Name: ____________________________ DOB: ____________________________

Address: ____________________________ Guardian: ____________________________

____________________________ Phone: ____________________________

Authorization #: ____________________________ Auth period: ____/____/_____to_____/____/____

☐ Youth/guardian is a Non-English-speaking. Please specify language: ____________________________

Referral Agency: ____________________________

Referred By: ____________________________

Contact Phone: ____________________________ Fax: ____________________________

E-mail:____________________________

Reason for Referral: ____________________________

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Please select from the following services:

☐ Individual Therapy

☐ Group Therapy:

____Anger Management ____DBT Skills Group for Teen Girls _____Executive Functioning Group ____Social Skills Group

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Insurance comments: ____________________________

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