Entered in ❑ ICA Notes ❑ AMD ❑ Scanned ❑ Insurance

South Shore Behavioral Health Clinic

Client Referral Form - **Fax: 339-788-9904**

Purpose of this form: ❑ OUTREACH ❑ OFFICE ❑ Psychological Testing ❑ School ❑ IHT/TM
❑ New Intake ❑Update ❑ New Demographics ❑ Telehealth ❑ Transferring to New clinician

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Referral Date _____ ____Referral Source_____ ____Client LD_____

Client Name_____S.S.# _____

Address _____ D.O.B._____Age_____

City _____ _____ State _____ _____ Zip_____

❑ Male ❑ Female ❑ Trans ❑ Bisexual ❑ non Binary ❑ Other _____

Identified Gender: _____ Identified Race: _____

Identified Ethnicity: _____Birth Gender ❑ Male ❑ Female

Horne Phone # _____ OK to Say Agency Name? ❑ Yes ❑ No

Work Phone #_____ OK to Say Agency Name? ❑ Yes ❑ No

Other Phone #_____OK to Say Agency Name, ❑ Yes ❑ No

Parent/Guardian _____

Ins. Co. _____Plan_____Managed by_____

Ins. # _____Group#_____, Phone _____

2nd Ins. Co._____Ins.# _____, Phone_____

Primary Subscriber_____DOB_____S.S. #_____

Deductible $_____Benefit Limits_____Visits_____Co-pay $_____Visits_____Co-Pay Increase $_____

Authorization Required ❑Y ❑ N

Therapy Auth #_____From_____To_____# Visits Authorized_____

P resenting Problem:

❑ Individual Therapy ❑ Psychological Testing
❑ Coup1esTherapy ❑ Group Therapy
❑ Psychiatric Evaluation ❑ Family Therapy

Prior treatment? Where/when _____

Current treatment Where? _____

Is client currently (or in past) on medication(s)? If so, list _____

Prescribed by whom _____

Therapist (Male/Female)_____Available Times_____

DSM Diagnosis

Axis I_____

Clinician Signature_____Date:_____