South Shore Behavioral Health Clinic

200 Cordwainer Drive, Suite 200
Norwell, MA 02061
Main Office: (781) 878-8340
Fax: (339) 788-9904

General Client Referral Form

Entered in: ICA Notes AMD Scanned Insurance

Purpose of this form: ❑ OUTREACH ❑ IN OFFICE ❑ Psychological Testing ❑ School Based
❑ New Intake ❑Home Based ❑ New Demographics ❑ Telehealth ❑ Transferring to New clinician

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Referral Date: _____Referral Source: _____ Client LD: _____

Client Name:_____ D.O.B: _____ Age:_____

Address: _____

City: _____ State: _____ Zip: _____

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

Identified Gender: _____ Identified Race: _____

Identified Ethnicity: _____ Birth Gender: ❑ Male ❑ Female

Home/Cell 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 Name: _____Email:
_____

Ins. Co.: _____ Plan: _____

Ins. # _____ Managed by: _____ 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_____

Presenting Problem:

❑ Individual Therapy ❑ Psychological Testing ❑ CouplesTherapy

DSM-V Diagnosis: _____

ICD-10-CM (F-code): _____

Clinician Signature/credentials: _____

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❑ Psychiatric Evaluation ❑ Family Therapy

Prior treatment? Where/when:_____

Current treatment? Name/Contact: _____

Any current/past medications:_____ Prescriber:_____

Therapist (Male/Female_____ Availability: _____

DSM-V Diagnosis: _____

ICD-10-CM (F-code): _____

Clinician Signature/credentials: _____