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|  | The Healing Place**Referral Form** |

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| --- | --- | --- | --- | --- |
| **Date of Referral:** |  |  |  |  |
|  |  |  |  |
| **Client Name:** |  | **Date of Birth:** |  |
|  |  |  |  |
| **Client’s Gender Identity:** | [ ]  Male [ ]  Female [ ]  Other | **Client’s Primary Language:** |  |
|  |  |  |  |
| **Client Address:** |  |
|  |  |  |  |
| **Primary Reason for Referral:** |  |
|  |  |
| **If client is a minor or has a legal guardian please complete the information below:**  |
| **Parent/Caregiver Name:** |  | **Parent/Caregiver****Date of Birth:** |  |
|  |  |  |  |
| **Parent/Caregiver****Phone#:** |  | **Parent/Caregiver****Email Address:** |  |
|  |  |
| **Additional Contact Information:** |  |
|  |
| **If client has medical insurance, please complete write the information below:** |
| **Insurance Provider:** |  | **Group#** |  | **Member ID:** |  |
|  |  |
| **Additional Information:** |  |
|  |  |  |
| **How were you referred to The Healing Place?** | [ ]  Insurance Provider [ ]  Another Provider [ ]  Psychology Today [ ]  Employee Program | [ ]  Social Service Agency [ ]  Another Client/Parent[ ]  Internet search/Website[ ]  Other: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |