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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: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | |