caladrius

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www.caladriustherapy.com

**DATE:** _____

**REFERRAL SOURCE** (AGENCY/PERSON) _____

ADDRESS _____

PHONE_____

FAX NUMBER _____

EMAIL ADDRESS_____

**CLIENT'S NAME** _____ DOB _____

SEX AT BIRTH_____ GENDER _____ PRONOUNS_____ AGE _____

(IF MINOR) PARENT/LEGAL GUARDIAN"S NAME _____

☐ BIOLOGICAL PARENT ☐ LEGAL GUARDIAN (MUST PROVIDE LEGAL DOCUMENTS FOR VERIFICATION)

ADDRESS _____

CELL PHONE (_____) _____ HOME PHONE (_____) _____

EMERGENCY CONTACT _____

HOME PHONE (_____) _____ WORK PHONE (_____)_____

**REASON(S) FOR REFERRAL (CHECK ALL THAT APPLY)**

☐ TRAUMA ASSESSMENT ☐ PARENT SUPPORT ☐ INDIVIDUAL THERAPY ☐ FAMILY THERAPY
☐ GROUP THERAPY ☐ PSYCHIATRIC EVALUATION ☐ EMDR
☐ OTHER: _____

**BRIEF DESCRIPTION OF REASON FOR REFERRAL** (ATTACH SEPARATE SHEET IF NECESSARY. PLEASE FORWARD MEDICAL & BEHAVIORAL INFORMATION, COURT REPORTS, SOCIAL SUMMARIES, PREVIOUS EVALUATIONS, ETC.)

_____

_____

_____

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## BILLING INFORMATION

☐ SELF PAY ☐ PRIVATE INSURANCE ☐ MEDICAID (PARTNERS MCO ONLY ACCEPTED)
☐ SLIDING SCALE REQUEST ☐ PRO BONO REQUEST ☐ EAP

**PRIMARY INSURANCE COMPANY** _____

**If** EAP: EAP Authorization # _____EAP # of Visits _____

**DOES CLIENT HAVE ANY OTHER FORM OF INSURANCE? YES/NO**