Project Aspiration Lighthouse Behavioral Health & Wellness Center

Project Aspiration Referral Form

Please email referrals to: referrals@lbhwc.com

Date of Referral: _____ Time of Referral: _____ Client #: _____

☐Intake Assessment ☐Offender Intervention ☐Domestic Violence Counseling
☐Safety Assessment ☐Advocacy Case ☐Community Education Service

(Office Use Only)	**Assigned To:**	Date Assigned:
Intake Date:		Date of First Contact:

Client/Family Name:	DOB:	Gender:
Name of Caretaker	Relationship to Client/Family:	
Emergency Contact:	Emergency Contact Phone No:	
If child is a minor, who has legal and physical custody:		
Counselor Preference:☐ Female☐ Male☐ Either	Email Address:	
Address:		
Preferred Phone No:	Back up/Alternative Phone #:	
Primary Language:	Interpreter?☐ Yes ☐No	Scheduling needs:
Nationality (Country of Origin):	Race:	
School:	Health Center/PCP:	

Referral Source Name:		Role with Family/Agency:
Phone:	Fax No:	Email Address:

Insurance Information: **If No Insurance ID, Social Security Number:**

Primary Insurance Plan: _____ Insurance ID #: _____
Secondary Insurance Plan: _____ Insurance ID #: _____
MMIS #: _____ Auth Approval #: _____
Date Authorization Submitted: _____ Date Authorization Approved: _____
Auth Start Date: _____ Auth End Date: _____ Units Approved: _____
Axis 1 (Current Diagnosis Dx Code(s): _____
Who generated diagnosis and when? _____

What are the current concerns or behaviors for the individual/family member (Patient) that led to the referral?

What has been helpful for the individual/family (Patient) currently or in the past? What are their strengths?