LIGHTHOUSE BEHAVIORAL HEALTH & WELLNESS CENTER

Group Referral Form

Please email referrals to: referrals@lbhwc.com

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

Please indicate which support group this referral is for:

- ☐Perinatal Mental Health
- ☐Teen Pregnancy
- ☐Mindfulness/Meditation
- ☐Life Over Matter/Life Workshop
- ☐Anxiety Management
- ☐Substance Abuse Recovery
- ☐Healthy Relationships
- ☐Cognitive Behavioral Therapy (CBT)
- ☐Parenting Skills Workshop
- ☐Coping Skills Workshop
- ☐Recreational Activities
- ☐Teen Support
- ☐Youth Grief
- ☐Parents of Addicted Youth
- ☐Adult Domestic Violence
- ☐Domestic Violence Offender
- ☐Depression Support
- ☐Trauma Recovery
- ☐Dialectical Behavior Therapy (DBT)
- ☐Mental Health Education
- ☐Art Therapy
- ☐Veterans Support
- ☐COVID Peer Support
- ☐Parenting
- ☐Divorce
- ☐Adult Grief
- ☐Grief & Loss Support
- ☐Self Esteem & Confidence Building
- ☐Mindfulness and Meditation
- ☐Stress Management
- ☐Music Therapy
- ☐Chronic Illness Support

(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?