



# Referral Form

Please email referrals to: [referrals@lbhwc.com](mailto:referrals@lbhwc.com)

Date of Referral: \_\_\_\_\_ Time of Referral: \_\_\_\_\_ Client #: \_\_\_\_\_

- Couple Therapy
- Community Support
- Family Therapy
- Family Stabilization Services
- School Based Therapy
- Trauma Center
- Outpatient Therapy

<b>(Office Use Only) Assigned To:</b> _____		Date Assigned: _____
Intake Date: _____	Date of First Contact: _____	

<b>Client/Family Name:</b> _____		DOB: _____	Gender: _____
Name of Caretaker: _____		Relationship to Client: _____	
Emergency Contact: _____		Emergency Contact #: _____	
If client is a minor, who has legal and physical custody: _____			
Counselor Preferences: _____		Email Address: _____	
Address: _____			
Preferred Phone #: _____		Alternative Phone #: _____	
Primary Language: _____	Interpreter? <input type="checkbox"/> Yes <input type="checkbox"/> No	Scheduling needs: _____	
Nationality (Country of Origin): _____		Race: _____	
School: _____		Health Center/PCP: _____	

- In-Person Services
- Telehealth Services
- Hybrid Services

<b>Referral Source Name:</b> _____		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?