Tides of Mind Counseling

PRIVATE THERAPY REFERRAL FORM

Date:_____ Referral Source:_____

Therapy Program Request (Circle one): **Waterbury Office** **In-Home Program** **Torrington Office**

CLIENT INFORMATION:

Client Name: _____ Guardian(s): _____

Date of Birth: _____ Age: ____ Marital Status:_____Social Security Number: _____

Home Address: _____

City: _____ State: _____ Zip: _____

Home Phone: _____Cell Phone: _____ Business Phone: _____

Email Address:_____ Preferred: HPhone /CPhone /BPhone /Email /Text

Employment Status- FT /PT /Ret /Un Employer:_____

Personal Physician & Phone Number:_____

Prescribing Psychiatrist & Phone Number:_____

Name of Attending School:_____ Grade:_____

School Address & Contact:_____

HEALTH INSURANCE CARRIER :

Name of Insurance Plan or Program: _____

Policy Number: _____ Group Number: _____

Policyholder (self, spouse, parent, etc.): _____DOB:_____

Policyholder's Address:_____

Additional health insurance _____

Deductible:_____ Copay:_____

PRESENTING PROBLEM:

_____

_____

_____

_____

_____

Current/Past Providers:_____

Prescribed Medications: _____

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