# The Healing Center for Change, LLC

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## *Adult Client Referral Info Form*

**Today's Date:**_____

**Referral Agency/Contact:**_____**Referral Phone #:** _____

**Client's name**:_____**Date of Birth**_____**Age:**____Gender: ☐ F ☐ M

Ethnicity: ☐ Caucasian ☐ African-American ☐ Asian ☐ Hispanic ☐ Native American ☐ Other

Brief reason for seeking treatment: _____

**Service(s) Requested**: _____ Religious Affiliation (if applicable): _____

Address:_____City:_____State:_____Zip: _____

Home or Work Number_____Okay to leave a message? ☐ Yes ☐ No

Cell Phone Number_____ Okay to leave a message? ☐ Yes ☐ No

Cell Phone Carrier: _____ Email: _____

Employer _____ Type of Work_____

Marital Status _____ Spouse/Partner Name (If applicable) _____

Spouse/Partner Home Phone _____ Spouse /Partner Cell Phone _____

Emergency Contact Person_____Relationship to client:_____

Emergency Contact's Phone Number: _____

**INSURANCE INFORMATION ~Please provide insurance card~ (Skip if self-pay)**

Policyholder's Name_____Policyholder's SSN: - -

Date of Birth / / Primary Insurance Co. Name _____

Insurance Company's Customer Service Phone # _____

Insurance ID #_____Policyholder's Employer: _____

Group #_____Co-pay $ _____ Deductible? ☐ Yes ☐ No

Amount $_____ Authorization Required? ☐ Yes ☐ No

Authorization # _____ Number of Sessions Authorized _____

**REASON** you are requesting Behavioral/Mental Health Services? (Describe the problem(s))

_____

_____

_____

Is the client (check all that apply)

- ❑ Age 18 years or older and not enrolled in a K-12 educational program?
- ❑ At risk of out of home placement (hospital, MH residential, SA residential, etc.)?
- ❑ Been identified to have a mental health, DSM-IV, diagnosis?
- ❑ Expressed ideations or attempted suicide or homicide in the past?
- ❑ Committed acts of physical or verbal aggression against others?