Outpatient Psychotherapy Referral Form

Referral Source	
Person Making Referral:______________________	Date of Referral:______________
Referral Organization:________________________	Phone #:____________________
Address:____________________________________	Fax#:_______________________
Email:______________________________________	
How did you hear about Birchwood Behavioral Health?__________________________	

Client Information	
Client Name:______________________________	Date of Birth:____________________
Client Address:_____________________________	Phone #:_______________________
Parent/Guardian:____________________________	Phone #:_______________________
Primary Insurance:________________________	Policy #:_______________________

Requested Services	
☐ Individual Therapy	☐ Child
☐ Couples Therapy	☐ Adult
☐ Family Therapy	
☐ Group Therapy	
☐ Parenting Classes	

Reason for Referral
Concerns:
Symptoms/Behaviors at Home, School, Work, or in the Community:

Please attach any information you think might be necessary. If you would like to be contacted with updates, please attach a signed ROI.