BIRCHWOOD
behavioral health

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.