OUTPATIENT THERAPY

REFERRAL FORM

For outside agencies, medical practices, schools, and community partners referring a client.

1 CLIENT INFORMATION

CLIENT LEGAL NAME

PREFERRED / CHOSEN NAME

DATE OF BIRTH

PRONOUNS

GENDER IDENTITY

STREET ADDRESS

APT / UNIT

CITY

STATE

ZIP CODE

CLIENT PHONE

CLIENT EMAIL

SAFE TO CONTACT CLIENT BY: Phone call Text Email May leave voicemail

PREFERRED LANGUAGE

TERPRETER N EDED? Yes No

2 PARENT / GUARDIAN INFORMATION (IF APPLICABLE)

PARENT / GUARDIAN NAME

RELATIONSHIP TO CLIENT

PHONE

EMAIL

3 INSURANCE INFORMATION

INSURANCE COMPANY / PLAN

MEMBER ID

POLICYHOLDER NAME

POLICYHOLDER DATE OF BIRTH

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4 REFERRAL DETAILS

PRIMARY REASON FOR REFERRAL / PRESENTING CONCERNS

REQUESTED SERVICE(S) - CHECK ALL THAT APPLY

- Individual therapy
- Couples / relationship therapy
- Family therapy
- Teen therapy
- LGBTQ+ affirming therapy
- Sexual health therapy

CLINICAL / DIAGNOSTIC INFORMATION (IF KNOWN)

CURRENT SAFETY CONCERNS

- None known
- Suicidal thoughts / risk
- Risk to others
- Other

EXPLAIN CURRENT OR RECENT SAFETY CONCERNS

This form is not monitored for emergencies. For immediate danger, call 911 or go to the nearest emergency department.

REFERRAL PRIORITY Routine | Soon (within 1-2 weeks) | Urgent (not an emergency)

FORMAT PREFERENCE In-person | Virtual | Either

LOCATION PREFERENCE Naugatuck | West Hartford | Virtual / no preference

SCHEDULING AVAILABILITY / CLINICIAN PREFERENCES / ACCESSIBILITY NEEDS

5 REFERRING PROVIDER / AGENCY

REFERRER NAME & CREDENTIALS

AGENCY / PRACTICE

PHONE

EMAIL

FAX

RELATIONSHIP TO CLIENT

DATE OF REFERRAL

I confirm the client/guardian is aware of this referral and has authorized contact by MisterHealth.

SUBMIT COMPLETED FORM

Email: Hello@MisterHealth.com

Fax: (860) 920-7320