I.M. Wellness Center
Life begins at the end of your comfort zone

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Referral Form

Please Print Clearly

Date of Referral: _____

Individual Information:

Individual Name: _____

Insurance Type: _____

Medicaid #_____**SS#**_____ **Date of Birth:** _____

Age: _____ **Grade Level**:_____ **Gender:** ☐Male ☐Female **Race**: _____

Address: _____**City**: _____ **State**: _____ **Zip**: _____

Home Phone#: _____ **Cell #:** _____ **Work #:** _____

Parent/Guardian: _____

Referral Source Information:

Name & Title of Person making referral: _____

Agency: _____ **Court Mandated?** ☐ **Yes or** ☐ **No County:** _____

Phone # of person making referral: _____ **Fax number:** _____

Email address:_____

Service(s) Requested:

☐ Therapy (Individual, Family, and Skills 1-3 visits per week)
☐ Assessment & Evaluation
☐ Life Coaching

Reason For Referral:

Please check all that apply and provide brief description below:

☐ **History of Counseling** ☐ **Suicidal/Homicidal/Self-Harming** ☐ **Substance Abuse/Dependence**

☐ **Legal Involvement** ☐ **Out of Home Placement** ☐ **Hospitalizations** ☐ **Psychosis**

☐ **Medication Use** ☐ **History of Abuse/Trauma** ☐ **Risk/History of Homelessness**

☐ **DFCS involvement** ☐ **Psychological/Psychiatric Eval completed (please attach to referral)**

_____

_____

For Office Use Only **Referral Received Date:** _____

Ins. Verified: ☐ Yes ☐No **Ins. Status:** Active Inactive Self-Pay

Date of Referral Verification: _____ **Spoke with:** _____

Assessor Assigned: _____ **Date Assigned:** _____

Thank you for choosing I.M. Wellness Center, LLC