

Referral Form / Application Template

Field	Example
Client Initials / Case #	
Age	
Service Requested	<input type="checkbox"/> Therapy <input type="checkbox"/> Medication Mgmt <input type="checkbox"/> Evaluation <input type="checkbox"/> Other_____
Urgency	<input type="checkbox"/> Routine <input type="checkbox"/> Urgent (1-week) <input type="checkbox"/> Crisis follow-up
Estimated Cost	\$_____
Referring Provider	_____
Facility	
Insurance Status	<input type="checkbox"/> Lost coverage <input type="checkbox"/> Pending <input type="checkbox"/> Uninsured
Additional Notes	
Provider Signature / Date	