Fax, Mail, or Email this form: Fax: (240) 560-6065; Mail: 8701 Georgia Ave., Suite 401, Silver Spring, MD 20910. Email: Rwynne@TestingandTherapy.com

Referral Source Information **Date: _____**

Referral Source (Name/Agency): _____

Address: _____ City: State: Zip _____

Phone: Work/Cell/Fax (if any) _____ E-mail_____

Client Information

Client's Name_____ DOB: _____ SSN: _____

Address:: _____ City State: Zip _____

Phone: Work/Cell: _____ E-mail _____

Emergency Contact:_____ Daytime Phone: _____

Relationship: □ Parent □ Legal Guardian □ Spouse/partner □ Social Worker □ Other _____

Name of attorney (if any)_____Phone:_____

Address: _____ City State: Zip _____

Who do I contact to set up appointment? _____Phone: _____

Best time(s) to call? _____

Reason(s) for Referral (check all that apply)

□ Therapy/Counseling □ Court ordered □ Next hearing date (if known) _____

□ Psychological evaluation □ Substance Abuse □ Report/Evaluation needed □ Other _____

□ Couple/Family issues □ Testimony required

Brief Description of Problem. (Use a separate sheet if necessary. Please forward relevant medical & behavioral information, court reports, reports from previous evaluations, social summaries, etc.)

Payment Information: □ Private insurance □ Self-pay □ Other_____

Co pay (if known) $_____ Deductible still owed this year (if known) $_____

Responsible party for fee payments: □ Client □ other party _____

Insurance ID # _____Group # _____

Insurance Provider Relations Telephone # _____

Claims address _____

Name/Birthdate/SSN/Address of insurance subscriber (if not client)

_____