Referral Form

Phone: 419-475-4449
Fax: 419-479-3844

Client Name: _____ Client #: _____

Date of Birth: _____

SSN: _____ - _____ - _____ Male_____ Female _____

Parent / Guardian Name: _____

Address: _____

Phone Number: _____ Interpreter Needed: Yes ___ No ___

Insurance Provider: _____

Insurance ID #: _____ Group #: _____

Referring Provider Name: _____

Practice Name: _____

Address: _____

Phone Number: _____ Fax: _____

Date of Referral: _____

Appointments and Referrals

☐ **Therapy**

Day/Date: _____ am / pm

Location: _____With: _____

☐ **Psychiatric Evaluation**

Day/Date: _____ am / pm

Location: _____With: _____

**Parent/Guardian MUST be present at the Psychiatric Evaluation*

☐ **Substance Use Assessment/Treatment**

Day/Date: _____ am / pm

Location: _____With: _____

☐ **Diagnostic Assessment** (If new patient to Harbor)

Day/Date: _____ am / pm

Location: _____With: _____

☐ **Psychological Testing** A referral has been made and a letter will be mailed to schedule the first appointment.

Please fax a copy of pertinent patient records to 419-720-6118

If you need to cancel or change an appointment, please contact the office where your appointment is scheduled.

If you have any questions, do not hesitate to contact us. We look forward to working with you.