Psychotherapy Referral Form

Referring Individual

Name

First Name Last Name

E-mail

example@example.com

Phone Number

Referral Details

Client Name *

First Name Last Name

Date of Birth & Age *

Date of Birth Age

Phone Number *

Referral E-mail *

Address *

Street Address

Street Address Line 2

City

State / Province

Postal / Zip Code

Parent/Guardian Name (if applicable)

Current Diagnosis (if known)

Insurance Type *

- Medicaid
- Rocky Mountain Health Plans
- United Healthcare
- BCBS of Colorado
- OptumHealth
- Cigna
- Humana
- Aetna
- Private Pay
- Other

Insurance Number *

N/A if using Private Pay

Services Requested *

- Individual Therapy
- Family Therapy
- Sibling Therapy

- Play Therapy
- Group Therapy
- EMDR Therapy
- Substance Abuse Counseling
- Other

Reported Symptoms

- Anxiety
- Depression
- Self-Esteem
- Trauma
- ADHD
- Suicidal / Homicidal Ideation
- Anger / Aggression
- Tantrums / Outbursts
- Social Isolation / Changes
- Family Dynamic Changes
- School Challenges

Additional Symptoms or Information

Scheduling Preferences

Please provide a few details regarding the client's general availability, if known, to accommodate as much as possible.

Day(s) Available

- Monday
- Tuesday
- Wednesday
- Thursday
- Friday
- Saturday
- Sunday

Time(s) Available

- Morning (8:00 AM to 11:00 AM)

Early Afternoon (12:00 PM to 3:00 PM)
Late Afternoon (3:00 PM to 5:00 PM)
Evening (5:00 PM to 8:00 PM)

Therapeutic Preferences (choose all that apply)

In-Person
Telehealth
Male Therapist
Female Therapist
Other

Are you requesting a specific therapist? If so, please list their name(s) here: