Wellsprings Psychological Resources

Referral Form

Date: _____ **Time:** _____

Client Name: _____ **DOB:** _____ **Age & Gender:** _____

Mailing Address:_____

Contact Parent or Legal Guardian (for minors): _____

Custody Arrangement (if applicable): _____

Telephone No: _____ **Email Address:** _____

Name of Insurance Company & Member ID #: _____

Provider Services Phone Number (if applicable):_____

Policy Holder/Guarantor Name & DOB: _____

Self-pay (if applicable) _____ **Referred by:** _____

Describe the reason you are seeking services: _____

_____

_____

_____

_____

Are you seeking counseling and/or a psychological evaluation?

_____

_____

_____

_____

Are you a previous client of Wellsprings? _____ **Previous counselor:** _____

Would you like Christian counseling? (using prayer, Christian resources, etc.) _____