NIALife
CENTER FOR COUNSELING

PATIENT REFERRAL FORM

Patient Name:	☐Male ☐Female	**Age**	**Date of Birth**
Parent/Guardian Name (If applicable):		**Relationship to Patient**	
Address		**Telephone**	**Email**

Referrer Information:
☐Doctor/Hospital ☐Employer ☐School ☐Court Ordered Treatment ☐Parent/Guardian ☐Self Referred
☐Other_____

Insurance Provider:
☐Medicaid ☐ Private Health Insurance ☐ Self Pay

Name of Health Plan_____
Insurance ID Number_____

REASON FOR SEEKING SERVICES

Have you experienced any problems at home? ☐Yes ☐No If yes, Explain.

Have you experienced any problems at school or work? ☐Yes ☐No If yes, Explain.

Have you experienced any problems in the community? (Legal problems, problems getting along with others) ☐Yes ☐No
If yes, Explain

Have you been experiencing these difficulties for more than 3 months? ☐Yes ☐No

Have you been seen by another mental health provider in the last year? ☐Yes ☐No If yes, Please Name the Provider

Name of School/Employer	Grade (if applicable)

How did you find out about us?

Office Use Only

Level of Care:
☐Emergent Care (6 hours) ☐Urgent Care (48 hours) ☐Routine (14 Calendar Days)
☐Not Eligible for Services
If not eligible, Identify Outside Resources this Person is Referred to:
Assessment Appointment Date/Time:

Did this person meet their Intake and Assessment Appointment Date? ☐Yes ☐No	If no, were they contacted to reschedule? ☐Yes ☐No New Assessment Appointment Date/Time:

Is this person approved for services? ☐Yes ☐No If no, explain

Name of Person Taking Information:	Date:

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