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20B East Roseville Road
Lancaster, PA 17601
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REFERRAL SHEET

Completed by: _____

Referral: Therapy Meds BHRS Brief Tx Grps ABCs IOP PCIT Other _____

Referred By/Caller _____

Referral Date _____

Name of Client _____

Date of Birth _____ Gender: M F

Client Address _____

Client Marital Status _____

City _____ State _____ Zip _____

Phone _____

Social Security # _____

MA ID# _____

Name(s) of parents/guardians? _____

School _____

Are there any legal custody issues? Y N If yes, please provide names and contact information for all parties on the back.

Educational Rights _____

Medical Rights _____

Include copies of custody agreements and/or court documents verifying legal, medical and educational rights.

Name of Insured _____

Insured Date of Birth _____

Insurance Employer _____

Insured ID# _____

Insurance Carrier _____

Insurance Phone # _____

Insurance Information _____

Areas of Concern? _____

Is the Client in treatment now? Where? _____

If yes, when was last psychiatric evaluation? _____

Current Diagnosis (if any) _____

Days Available: Monday Tuesday Wednesday Thursday Friday Times: _____

Office Use Only

CDB Tracking

Appointment Scheduled IA Psych Eval Psychiatric IOP Tracking Custody

Date _____ Time _____ Evaluator _____

Date _____ Time _____ Doctor _____

The earliest available intake was more than two weeks away; caller was offered provider freedom of choice information.