***Client Referral Form***

Please **FAX** this form and pertinent medical records and information to **443-982-0610,** or

Please **SCAN** andemail to **coachmentalhealth.ebony@gmail.com**

**Client Information**

      **[ ]**  Male **[ ]**  Female **[ ]** Transgender

Client Name

Date of Birth Phone Number(s)

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Parent/Guardian Name (if applicable)

**Insurance Information**

Name of Insurance Policy or MA #

**Appointment Timeframe**

**[ ]**  Urgent – within 48 hours **[ ]** Priority – within 2 weeks **[ ]** Routine – within 30 days

**Previous Treatment**

**[ ]** Yes **[ ]** No

Clinician Name and Contact Information

Presenting Problem/Diagnosis/Reason for Visit

ICD-9 Code (optional)

**Referred By**

Name Title/Relationship

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Signature Phone Number(s)