C . O . A . C . H .
Counseling Outreach Advocacy Change Hope

C.O.A.C.H. Mental Health, LLC

Client Referral Form

Please **FAX** this form and pertinent medical records and information to **443-982-0610,** or
Please **SCAN** and email to **coachmentalhealth.ebony@gmail.com**

Client Information

_____ ( ) Male ( ) Female ( ) Transgender
Client Name

_____ _____
Date of Birth Phone Number(s)

_____
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

_____ _____
Signature Phone Number(s)