**REFERRAL FORM**

**Referral Source Information:**

Person Making Referral: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_

Referral Organization: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Phone #:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Office Contact Person: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Fax #:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Patient Information:**

Patient Name:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Date of Birth:\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Parent/Guardian (if applicable):\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Phone #:(\_\_\_\_) \_\_\_\_\_\_\_\_\_\_\_\_\_\_ Primary Insurance:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Subscriber Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Patient Referred for:** (check all that apply)

* Psychotherapy/Counseling
* Anxiety
* Depression
* Trauma
* Grief/Loss or Life Change
* Loss of job
* Mood disorder
* Insomnia
* Behavior change
* Personality disorder
* Relationship issues
* Stress management
* Other \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_(Please specify)

**Patient’s Release of Information:**

I authorize this referral source to share this form with Balance Point Counseling & Wellness, PLLC staff for the purpose of discussing and scheduling my appointment. An additional release of information will be required to discuss treatment.

Patient signature: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Please return this form via email; balancepoint365@gmail.com, or mail;

844 Grand Ave, Suite C, Grand Junction, CO 81501. The patient will contacted by Balance Point Counseling & Wellness, PLLC, within 3 business days of receiving this form. Thank you for your referral!