

**Fax, Mail, or Email this form:**

**Fax:** (301) 587-2102

**Mail:** 1109 Spring St., Suite 403, Silver Spring, MD 20910

**Email:** [Rwynne@TestingandTherapy.com](mailto:Rwynne@TestingandTherapy.com)

**Referral Source Information**

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

Referral Source (Name): \_\_\_\_\_ Agency: \_\_\_\_\_

Address: \_\_\_\_\_ City: \_\_\_\_\_

County: \_\_\_\_\_ State: \_\_\_\_\_ Zip Code: \_\_\_\_\_

Phone: \_\_\_\_\_ Fax: \_\_\_\_\_

**Client Information**

Client's Name: \_\_\_\_\_ DOB: \_\_\_\_\_ SSN: \_\_\_\_\_

Race/Ethnicity \_\_\_\_\_

Address: \_\_\_\_\_ City: \_\_\_\_\_

County: \_\_\_\_\_ State: \_\_\_\_\_ Zip Code: \_\_\_\_\_

Phone: \_\_\_\_\_ Cel: \_\_\_\_\_

**Emergency Contact:** \_\_\_\_\_ Daytime Phone: \_\_\_\_\_

Relationship to client:  Parent  Legal Guardian  Spouse/partner  Social Worker  Other \_\_\_\_\_

Name of attorney (if applicable) \_\_\_\_\_ Phone: \_\_\_\_\_

Address: \_\_\_\_\_ City: \_\_\_\_\_ State: \_\_\_\_\_ Zip Code: \_\_\_\_\_

Who do I contact to set up appointment? \_\_\_\_\_ Phone: \_\_\_\_\_

Best time(s) to call? \_\_\_\_\_

**Reason(s) for Referral (check all that apply)**

Therapy/Counseling  Court ordered  Next hearing date (if known) \_\_\_\_\_

Psychological evaluation  Substance Abuse  Report/Evaluation needed  Other \_\_\_\_\_

Couple/Family issues  Testimony required

**Brief Description of Problem.** (Use a separate sheet if necessary. Please forward relevant medical & behavioral information, court reports, reports from previous evaluations, social summaries, etc.)

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

**Payment Information-Select One:**

Private insurance  Medicare  Medicare/insurance  Self-pay  Other \_\_\_\_\_

Co pay amount listed on insurance card (if any) \$ \_\_\_\_\_ Deductible still owed this year (if known) \$ \_\_\_\_\_

Responsible party for fee payments:  Client  other party (Name) \_\_\_\_\_

Relationship to client \_\_\_\_\_

Insurance carrier: \_\_\_\_\_ Insurance ID # \_\_\_\_\_ Group # \_\_\_\_\_

Medicare # (if any) \_\_\_\_\_ Insurance Provider Relations Telephone # \_\_\_\_\_

Claims address: \_\_\_\_\_

Name & address of insurance subscriber (if not client) \_\_\_\_\_

\_\_\_\_\_  
\_\_\_\_\_