## Pathways to Well-Being, Inc.

## REFERRAL – NEW PATIENT FORM

NAME:______________________________ DOB:______________

PHONE NUMBER(S):_________________ _________________
(HOME) (CELL)

PATIENT ADDRESS: ________________________________________________

PARENT/GUARDIAN ADDRESS: ______________________________________

______________________________________

PRIMARY INSURANCE: ______________ ID#__________ Policy#_________

SECONDARY INSURANCE: __________ ID#__________ Policy# _________

Policy Holder Name: _____________ DOB: _______ Relation to Pt.:_____ COPAY: _________
CO-INSURANCE: ___________

ELIGIBILITY#______________________

Referral Name/Number______________________________________________________

**Reason(s) for counseling (Circle**): abuse Anger management anxiety body image ptsd cultural issues depression family grief identity issues marital/couples self-harm mental health eval ocd phobias social isolation stress substance abuse
court ordered mental/substance eval (judge/po: _________________)

if not listed above, please list reason(s) for counseling:_____________________________________________________________________________________
_____________________________________________

date of counseling appt. & Provider: ______________________________

**reasons for medication management:** add adhd ocd odd ptsd anxiety bipolar depression grief mood schizophrenia substance med eval for diagnosis

current medications (if any): _______________________________________

date of med appt & provider: _______________________________________

information taken by: _______________________________   date: __________