**Referral Form**

|  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- |
| Date | Click or tap to enter a date. | | | | | |
| Service Requested | Intensive In-home  Mental Health Skill Building  Outpatient Therapy | | | | | |
| **Clients Legal Name** |
| First Name | | Click or tap here to enter text. | | Last Name | | Click or tap here to enter text. | |
| Clients Phone Number | Click or tap here to enter text. | | | | | |
| Gender Identity | | | Choose an item. | |

|  |  |  |
| --- | --- | --- |
| Language Needed for Service: | English  Other \_\_\_\_\_\_\_\_\_\_\_ | |
| Street Address | Click or tap here to enter text. | |
| Street Address Line 2 | Click or tap here to enter text. | |
| City | Click or tap here to enter text. | | State/Province | Click or tap here to enter text. |
| Postal Zip/Code | Click or tap here to enter text. | |
| **Guardian Name** |
| First Name | Click or tap here to enter text. | | Last Name | Click or tap here to enter text. |
| Guardian Phone Number | Click or tap here to enter text. | |
| Social Security Number | Click or tap here to enter text. | |
| Insurance ID | Click or tap here to enter text. | |
| **Primary Insurance Type: \*** | | Choose an item. | | | |

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| --- |
| Policy Holder |
| First Name | Click or tap here to enter text. | | Last Name | | | Click or tap here to enter text. | |
| Policy Holder Date of Birth | | | | | | Click or tap to enter a date. | |
| Policy Holder Address: | | | | | |
| Street Address | | Click or tap here to enter text. | | | |
| Street Address Line 2 | | Click or tap here to enter text. | | | |
| City | | Click or tap here to enter text. | | State/Province | | | | Click or tap here to enter text. |
| Postal Zip Code | | Click or tap here to enter text. | |
| Policy Holder Cell Number:  Please enter a valid phone number. | | | | | Click or tap here to enter text. | |
| Policy Holder Home Number:  Please enter a valid phone number. | | | | | Click or tap here to enter text. | |
| Policy Holder Work Number:  Please enter a valid phone number. | | | | | Click or tap here to enter text. | |
| Referent Name/Phone Number:  Please enter a valid phone number. | | | | | Click or tap here to enter text. | |
| **Presenting Problem/Issue:** | | | | | | | | | |
| Click or tap here to enter text. | | | | | | | | | |

**MH Providers: please attach clinical assessment(s), recent CANS, current treatment plan**

**Please return completed forms to:**

**Attn:** Shelia Wright

**Phone:** 804.462.7700

**Fax:** 804.462.5158

**Email:** [swright@excelintervention.com](mailto:swright@excelintervention.com)