pathways

OUTPATIENT MENTAL HEALTH CLINIC

Referral Form

*** Fax completed referrals to (240) 309-4131 Staff will contact the patient to schedule an intake appointment ***

CLIENT INFORMATION

Name:	**Date of Birth:**
Gender: ❒ Male ❒ Female ❒ Other_____	
Client's Preferred Service Location: ❒ Hollywood ❒ Lexington Park ❒ Waldorf	
CONTACT NUMBERS:	**Message ok?** ❒ Yes ❒ No
ADDRESS:	
Reason for Referral: ❒ Therapy ❒ Medication Management ❒ Both	

PARENT OR LEGAL GUARDIAN INFORMATION

Name of Parent or Legal Guardian:	**Address:**
Contact Number:	
Current Living Arrangement: ❒ Home ❒ Group Home ❒ Foster Home ❒ Inpatient Setting ❒ Other _____	

INSURANCE INFORMATION

Type of Insurance ❒ **Medicaid** ❒ **Medicare** ❒ **Private:**_____ ❒ **Self Pay**

INSURANCE ID: _____

GROUP# _____

PHONE #: _____

Name of Policy Holder: **DOB:** **SS#**

REFFERAL SOURCE

Name/ Title:	**Phone Number:**
Address:	