Kalamazoo Child and Family Counseling

Phone (269) 615-7637 or Fax (269) 269-389-07012 or 269-213-5557

REFERRAL FORM

Please check the reason(s) for referral:

- ☐ Outpatient Psychotherapy
- ☐ Pediatric Psychological Testing (<21 years of age)
- ☐ Pediatric Mental Health Clinic (<18 years of age)

Preliminary Diagnosis _____

Patient Name: _____ **Patient DOB:** _____

Patient Address:_____
Street City State Zip

Patient Social Security #_____ **Phone:**_____

Responsible Party (Must be completed) _____ **Phone:** _____

Responsible Party DOB_____ **Responsible Party's Email:**_____

Primary Insurance: _____
Policy # _____**Group #** _____
Policy Holder: _____

Secondary Insurance: _____
Policy # _____**Group #** _____
Policy Holder: _____

Please Include these documents:

- ☐ Demographic cover sheet with insurance information
- ☐ Last physical exam and/or last two visit notes clarifying rational for referral
- ☐ Past neuropsychological or psychological reports
- ☐ Most recent behavioral health visit (if applicable)
- ☐ Current Medication List / Adverse Reactions
- ☐ Past medications

Referring Physician: _____ Practice Address: _____

NPI of referring Physician: _____

Office Phone # _____ Office Fax: _____

Office Contact Person _____ Phone/ Extension _____

Primary Care Physician _____ PCP Phone _____ PCP Fax _____

Referring provider email address : _____

Helping Families Find More Shared Joy