



# 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:** \_\_\_\_\_ **Secondary Insurance:** \_\_\_\_\_

**Policy #** \_\_\_\_\_ **Group #** \_\_\_\_\_ **Policy #** \_\_\_\_\_ **Group #** \_\_\_\_\_

**Policy Holder:** \_\_\_\_\_ **Policy Holder:** \_\_\_\_\_

**Please Include these documents:**

- Demographic cover sheet with insurance information
- Last physical exam and/or last two visit notes clarifying rationale 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 : \_\_\_\_\_