



MindSpring

COUNSELING

Provider Referral for Behavioral Health Services

1. Referring Provider Information

Provider Name: _____

Practice/Organization: _____

Specialty/Title: _____

Phone: _____ Fax: _____

Email: _____

Preferred Contact: ☐ Phone ☐ Fax ☐ Email

2. Client Information

Client Name: _____

Date of Birth: _____

Phone: _____

Email: _____

Address: _____

Preferred Pronouns: _____

3. Referral Information

Reason for Referral: _____

Presenting Concerns/Symptoms (Circle all that apply):

Anxiety

Depression

Trauma/PTSD

AD/HD Spectrum

Behavioral Concerns

Family/Relationship

Grief/Loss

School Concerns

Work/Career

Stress/Adjustment

Mood Concerns

Autism Spectrum

Other: _____

Requested Services (Circle all that apply): Individual Therapy

Family Therapy

Child/Adolescent Therapy

Parent Support/Coaching

Vocational Counseling

Play/ Art Therapy

Preferred Frequency (Choose one): Weekly Biweekly Monthly As Clinically Indicated

4. Clinical Considerations

Current Diagnoses, if applicable: _____

Current Medications, if relevant: _____

Relevant Medical/Psychiatric History: _____

Current Safety/Risk Concerns (circle all that apply): None Reported Suicidal Ideation Homicidal Ideation Self-Harm Other: _____

If risk concerns are present, provide additional information: _____

5. Insurance Information

Insurance Provider: _____

Member/Policy ID: _____

Group Number: _____

Policyholder Name: _____

Relationship to Client: _____

6. Records/Supporting Documentation

Please attach relevant documentation, if available (Circle applicable) : Clinical Notes Diagnostic Evaluation Medication List Treatment Summary

Psychological/Psychiatric Evaluation Other: _____

7. Referral Authorization

I am referring the above-named client for behavioral health services. To the best of my knowledge, the information provided is accurate and relevant to the client's referral and treatment needs.

Referring Provider Signature:

Date: _____

Specialty/License
