Apex Psychological Services LLC

CLIENT REFERRAL FORM

Client's Name: _____ Phone: _____ Date of Birth: _____

Preferred Pronouns: _____ Email Address: _____

Address: _____ City: _____ State: _____ Zip: _____

Insurance Provider: _____

Policy Number: _____ Policy Holder Name (if different than client): _____

Referral Organization: _____ Referring Provider: _____

Address: _____ City: _____ State: _____ Zip: _____

Referral Source Number: _____ Fax Number: _____

Reason for Referral (in brief): _____

_____

_____

_____

_____

Is the client currently working with a therapist? ☐ Yes ☐ No ☐ Unknown

Therapist Name (optional): _____

The psychological services provided are aimed at supporting mental well-being and emotional growth. The psychologist does not diagnose physical illnesses or prescribe medication. We appreciate you providing relevant information about the client's mental health concerns.

Signature of Person Referring: _____ Date: _____

This form may be faxed or emailed to us.

CONTACT US

www.apexpsych.net

260 Amity Road, Suite 202 Woodbridge, CT 06525

Email (preferred): apexpsych2020@outlook.com - Phone: (203) 298 - 4572 - Fax: (203) 298 - 9007