Outpatient Treatment Referral Form

Please submit this form along with any other necessary documentation or releases of information. If you wish to fax, please include a cover sheet and send to (833) 373-0348

Phone: (501) 679-0232
info@insynccounseling.com

Referring To:_____ Date:_____

Rendering Provider:_____ Phone:_____

Client Demographics

Name:_____ Date of Birth:_____

Address:_____

Insurance Provider:_____ Policy ID:_____

Phone Number:_____ Group #:_____

Is client a Minor: □ Yes □ No Guardian Name:_____

Guardian Phone:_____ Relationship to Client:_____

Reason for Referral: _____

_____

_____

_____

Potential Risk Factors:

□ Current Suicidal Ideation/Behavior

□ History of Suicidal Ideation/Behavior

□ History of Trauma

□ History of Violent Behavior

□ History of Abuse

□ Other:_____

Current Medications (Please include dosage and frequency):_____

_____

Additional Notes: