Counseling and Trauma Therapy Associates

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Phone: (207) 216-2637 **Fax:** (207) 510-8054

Client Referral Form

Client Name: _____

Date of Birth: _____

Address: _____

Phone Numbers: _____

Referral Source Name: _____

Referral Source Contact Info: _____

Reason for Referral: _____

_____

_____

Service Requested: _____

Current Diagnosis (if any):_____

Current Insurance Information:

Insurance Provider: _____

Insurance Number: _____

Office Use Only

Date and Time Referral Received: _____

Insurance Verification Info: _____

Date of Insurance Verification: _____

Signature of Clinician: _____