Woodfords Family Services
Outpatient Services

Referral Form

Date of Referral: ______________ Date received at WFS: _____________

Requested Service (check one):

______ Therapy

______ Assessment (Please specify): ☐ LOCUS ☐ ABAS ☐ Diagnostic Question ☐Other:_________

Who is making referral: ____________________________ Contact Information:____________________

Child/Adult Name: ____________________________ Date of Birth: __________ WFS ID: ___________

Parents/Guardian Names (if applicable): ____

Address: ____

Home Phone: ____________________ Cell Phone: _________________ Work Phone: ____________

Primary Insurance and ID # (**Provide Copy of Card**): ____

Secondary Insurance and ID #: ____

Payment is due at the time of your scheduled session. Any insurance co-pays or deductibles are due at the time of the session. Payment can be made in cash or check. Unfortunately, we cannot extend credit or provide services until payment is made. *Clients understand they are fully responsible for all fees if insurance or other vendor does not pay for any reason.*

1. What is the presenting problem/reason for outpatient therapy?

2. What Diagnoses have been given and by whom?

3. Has outpatient therapy been attempted in the past?
    a. If so, was it successful?
    b. What methods were used?

4. What other services is the consumer involved in?

5. Are there certain days and/or times that work better for regularly scheduled appointments?

☐ After school times needed

☐ After 2 pm

☐ After 3 pm

☐ Morning appointments

☐ Between 8-9 am

☐ After 9 am

☐ Daytime hours are an option

Please check all that may apply:

☐ Monday ☐ Tuesday ☐ Wednesday ☐ Thursday ☐ Friday

Clinician Assigned: ______________________________________ Date:____________________

Date of initial contact by clinician_________________________

☐ Yes, consumer scheduled Date:________________________

☐ No, Consumer not scheduled Reason/Comment:

Notes: