Heritage Wellness Referral Form

REFERRING PROVIDER INFORMATION

1. Name:

   _____

2. Title/Role :

   _____

3. Organization / Practice Name :

   _____

4. Phone :

   _____

5. Email :

   _____

6. Fax (if applicable) :

   _____

CLIENT INFORMATION

7. Client Name :

_____

8. Date of Birth :

_____

Example: January 7, 2019

9. Phone Number :

_____

10. Email Address :

_____

11. Preferred Language :

Mark only one oval.

- ◯ English
- ◯ Spanish
- ◯ Haitian Creole
- ◯ Other: _____

12. Parent/Guardian Name :
(if minor)

_____

13. Parent/Guardian Phone :

_____

14. Reason For Referral :

Check all that apply.

- [ ] Anxiety or Panic
- [ ] Depression or Mood Changes
- [ ] Trauma / PTSD
- [ ] ADHD or Concentration Difficulties
- [ ] Stress or Burnout
- [ ] Grief / Loss
- [ ] Family or Relationship Concerns
- [ ] School or Work Challenges
- [ ] Culturally Sensitive or Faith-Based Care
- [ ] Other: _____

CURRENT CARE / SUPPORT

15. Is the client currently in therapy?

Mark only one oval.

- ◯ Yes
- ◯ No

16. Is the client currently on psychiatric medication?

Mark only one oval.

- ◯ Yes
- ◯ No

17. Current or recent provider(s) :

_____

18. Any safety concerns (self-harm, suicidality, etc.)?

Mark only one oval.

- Yes
- No

19. If yes, please describe briefly:

_____

_____

_____

_____

_____

INSURANCE INFORMATION (if available)

20. Insurance Provider :

_____

21. Member ID / Policy #

_____

22. Group #

_____

Heritage Wellness accepts select insurance plans and offers self-pay options with transparent rates. A member of our intake team will contact the client directly to confirm coverage and next steps.

URGENCY & PREFERRED CONTACT METHOD

23. Preferred appointment type :

Mark only one oval.

- ◯ Telehealth
- ◯ In-Person
- ◯ Either

24. Preferred timeframe :

Mark only one oval.

- ◯ Within 1 Week
- ◯ Within 2-3 Weeks
- ◯ Next Available

25. Preferred contact method for client :

Mark only one oval.

- ◯ Email
- ◯ Phone
- ◯ Text

AUTHORIZATION TO SHARE INFORMATION

26. I have obtained the client's consent to share this information with Heritage Wellness for the purpose of care coordination.

Referring Provider Signature

_____

27. Date :

Example: January 7, 2019