Hamner Psychological Services
Referral Information

Date:_____ Time:_____ Referral taken by:_____

Caller:_____ Relation to Client:_____

Phone:_____ Ext:_____ Fax:_____ Other:_____

CLIENT NAME:_____ Age:_____ DOB:_____

___Parent ___Foster Parent ___Guardian: _____

Phone: (home)_____ (work)_____ (cell)_____

Address:_____

City:_____ State:_____ Zip:_____

Referred By:_____ NPI #: _____

Service Requested:_____ Court Ordered: YES____ NO ____ Court Date: _____

Problem:_____

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If joint custody exists, ***both*** parents must consent to non-emergency medical/psychological care. Bring a copy of the divorce-parenting plan prior to the start of services.

Payment Source: ____ Private Pay ____ Medicaid ____ Medicare ____ Insurance ____ Other

Medicaid Information: Medicaid #_____

Has client been seen anywhere else this year: Yes ____ No ____ Where:_____

Type of service provided: Therapy _____ Other_____

Primary Insurance Information:

Ins Co: _____ Phone:_____

Policy Holder:_____ SS No:_____

Employer:_____ DOB:_____

Contract No:_____ Group/Plan No:_____

Is there another health benefit plan? Yes_____ No_____

Therapist Preference:_____ Therapist Assigned:_____ Office: ___Fmt ___ Bpt___

Appointment Date:_____ Time:_____ Outcome:_____

Notes:_____

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