



Group Referral Form

Please email referrals to: referrals@lbhwc.com

Date of Referral: _____ Time of Referral: _____ Client #: _____

Please indicate which support group this referral is for:

- Perinatal Mental Health
- Youth Grief
- COVID Peer Support
- Teen Pregnancy
- Parents of Addicted Youth
- Parenting
- Mindfulness/Meditation
- Adult Domestic Violence
- Divorce
- Life Over Matter/Life Workshop
- Domestic Violence Offender
- Adult Grief

(Office Use Only) Assigned To: _____		Date Assigned: _____
Intake Date: _____	Date of First Contact: _____	

Client/Family Name: _____		DOB: _____	Gender: _____
Name of Caretaker _____		Relationship to Client/Family: _____	
Emergency Contact: _____		Emergency Contact Phone No: _____	
If child is a minor, who has legal and physical custody: _____			
Counselor Preference: <input type="checkbox"/> Female <input type="checkbox"/> Male <input type="checkbox"/> Either		Email Address: _____	
Address: _____			
Preferred Phone No: _____		Back up/Alternative Phone #: _____	
Primary Language: _____	Interpreter? <input type="checkbox"/> Yes <input type="checkbox"/> No	Scheduling needs: _____	
Nationality (Country of Origin): _____		Race: _____	
School: _____		Health Center/PCP: _____	

Referral Source Name: _____		Role with Family/Agency: _____
Phone: _____	Fax No: _____	Email Address: _____

Insurance Information:

If No Insurance ID, Social Security Number:

Primary Insurance Plan: _____	Insurance ID #: _____
Secondary Insurance Plan: _____	Insurance ID #: _____
MMIS #: _____	Auth Approval #: _____
Date Authorization Submitted: _____	Date Authorization Approved: _____
Auth Start Date: _____ Auth End Date: _____	Units Approved: _____
Axis 1 (Current Diagnosis Dx Code(s): _____	
Who generated diagnosis and when? _____	

What are the current concerns or behaviors for the individual/family member (Patient) that led to the referral?

What has been helpful for the individual/family (Patient) currently or in the past? What are their strengths?