

**Referral Form for Mental Health Services**

**Client Information:**

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| Name: Date of Birth: Race/Ethnicity: |
| Gender: School & Grade: |

**Parent or Legal Guardian Information:**

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| Name of Parent or Legal Guardian: Relation to Child: |
| Contact Numbers: Address: |

**Payment Information:**

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| Type of Insurance: |
| Insurance ID#: Phone #: |

**Referral Source Information:** Complete this section so we can contact you after the referral is made.

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| Name: Mailing Address: |
| Phone#: Email address: |
| How did you hear about Resilient Roots, LLC? |

**PCP Information:**

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| Physician Name & Phone: |

**Reason for referral for treatment:** In your own words, describe the child‘s need for mental health services.

**Additional Comments:**

**Please email referral to** [brittany.jaspers@resilientrootsllc.com](file:///C:\Users\Redle_000\Desktop\Resilient%20Roots\forms\brittany.jaspers@resilientrootsllc.com)