Nemeth Counseling and Consultation LLC
Providing Affordable and Scientifically Based Counseling for Life

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EXTERNAL REFERRAL FORM FOR OUTPATIENT SERVICES

PROVIDER INFORMATION

Referring Provider's Name: _____ Phone: _____

Agency/Hospital Name:_____

Request confirmation of initial appointment: Yes / No

SERVICES NEEDED

__Individual Therapy __Couples Therapy __Family Therapy __Mediation __ Group _____

Other _____ **Location Preference**: __Hilliard __Westerville __First Available

CLIENT INFORMATION

Name: _____ DOB: _____

*If Minor, Guardian's Name:*_____ *Relationship to client:*_____

Phone: _____ Text Okay? Yes / No

Email: _____

Insurance: _____ Member ID: _____

Subscriber Name: _____ Subscriber DOB: _____

Primary Diagnosis: _____

Reason for seeking outpatient services*: _____

_____

*If hospitalized, anticipated Discharge Date:_____

Our Intake Team will contact the client directly and develop a safe and supportive transfer of services, inquire as to any accommodations, inform them of fees, and schedule the client with an appropriate clinician. ***We thank you for your referral!***

REV 8/18