Nemeth Counseling and Consultation

External Referral Form for Outpatient Services

PHONE: 614-849-8204
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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 Therapy
☐ Community-Based/In-Home ☐ Other: ____

Preferred Location: ☐ Hilliard ☐ Westerville ☐ First Available

CLIENT INFORMATION

Name: ____ DOB: __________________

*Guardian's Name: ______________________________ *Relationship to client: __________________
**If applicable*

Phone: _______________________________________ Email: ________________________________

Insurance Provider: _________________________________ Member ID: ________________________

Subscriber Name: ________________________________ Subscriber DOB: ________________________

Primary Diagnosis: ____

*Reason for seeking outpatient services: ____

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*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, and schedule the client with an appropriate clinician.
We thank you for your referral!

Revised: 2/2020; C. Ulry