



Clear Sky Wellness, PLLC

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CLIENT REFERRAL FORM

Today's Date: _____

CLIENT DEMOGRAPHIC INFORMATION:

Name: _____ Date of Birth: _____ E-mail: _____
First Middle Last

Address: _____ Work: ☐ Full Time ☐ Part Time ☐ Disability ☐ Unemployed ☐ N/A

Age: _____ School: _____ Grade: _____

Telephone: (____) _____ Leave Messages: ☐ Yes ☐ NO (____) _____ Leave Messages: ☐ Yes ☐ NO
Home Cell

Marital Status: ☐ Married ☐ Single ☐ Divorced ☐ Separated ☐ Widowed ☐ Significant Other: _____

Name of Spouse/Other: (if applicable): _____ Telephone: (____) _____ Leave Message?: ☐ Y ☐ N

If Minor:

Where does the child currently reside?: ☐ Both Parents ☐ Mom ☐ Dad ☐ Other: _____

Parent/Guardian's Name _____ Relationship: _____

Current Address: _____ Telephone No: _____

Parent/Guardian's Name _____ Relationship: _____

Current Address: _____ Telephone No: _____

INSURANCE INFORMATION:

1. Type of Insurance: ☐ No Insurance/Private Pay ☐ Major Medical ☐ Medicare ☐ (MA) Medicaid/ACCESS ☐ EAP ☐ Other

Insurance Name: _____ Policy/Member ID: _____ Group #: _____

Primary Card Holder's Name: _____ Date of Birth: _____

Relationship to Primary Card Holder: ☐ Self ☐ Spouse ☐ Child ☐ Other

2. Type of Insurance: ☐ No Insurance/Private Pay ☐ Major Medical ☐ Medicare ☐ (MA) Medicaid/ACCESS ☐ EAP ☐ Other

Insurance Name: _____ Policy/Member ID: _____ Group #: _____

Primary Card Holder's Name: _____ Date of Birth: _____

Relationship to Primary Card Holder: ☐ Self ☐ Spouse ☐ Child ☐ Other

REFERRAL SOURCE:

Referred By: _____ Title: _____ Telephone: _____

Facility/Office Name: _____ Address: _____

Email: _____ Fax: _____

REASON FOR REFERRAL:

Service(s) Requesting: ☐ Individual ☐ Family/Couple ☐ Evaluation (Specify): _____

If Evaluation, need by? _____ ☐ Other _____

Preferred Location: ☐ In Office ☐ Virtual Office

Brief summary of your concerns: _____

If Evaluation, date needed by? _____ Court Ordered? ☐ Y ☐ N Court Date? _____

Previous behavioral/mental health treatment? ☐ Yes ☐ No? Where: _____

For What? _____ By Whom/Where?: _____

What was the diagnosis/out come? _____

Comments: _____