ASPEN
mental health

Patient Referral

Date_____ Record /Alpha # (For Office Use Only)_____

Referral Source (Please send with copy of Insurance Card): _____

Referring Dr. NPI #_____

First Name _____Middle Initial_____Last Name_____

Address (No PO Boxes)_____

City_____State_____Zip_____

County_____ Date of Birth_____ Age_____

Marital Status_____

Home Phone_____ Work/Cell Phone_____

Legal Guardian/Relationship_____

Employer or School Attending/Grade_____

Emergency Contact Name_____ Phone_____

Primary Physician_____ Phone_____

Current Medications_____

Allergies_____

Any Known Communicable/Infectious Diseases _____

Concerns Requiring Counseling_____

Insurance Information

Insurance Company_____Name of Insured_____

Insured's SSN #_____Insured's D.O.B_____

Insured's Policy #_____Insured's Group #:_____

Insured's Employer_____

Insured's Relationship to Client _____

Authorization #:_____