+1 256.642.7400
+1 256.642.7600
office@spectrumMW.com
www.spectrummentalwellness.com

DATE: ____________________

# REFERRAL FORM

Patient Name: ____________________________________________ DOB: ______________

Parent / Guardian Name: __________________________ Patient Phone #: ___________________

Address: ________________________________________________________________

Insurance Carrer: ____________________________ Policy / Member #: ____________________

Being Referred By: __________________________ Agency Name: _______________________

Agency Phone #: ________________________ Agency Fax #: ________________________

## Reason for Referral (Please select one)

____ Psychological/Neuropsychological Testing*

____ Individual Therapy/Counseling

____ Family Therapy/Counseling

____Group Therapy/Counseling

*Testing Referral for:

____ Autism; ADHD; LD; Gifted; IQ

____ Anxiety; Depression; Mood; Psychosis

____ Behavior

____ Trauma

## Requested Provider

_____ Dr. Keri A. Bressette, Ph.D.

_____ Ida Wadsworth, LPC

_____ Susan Ratliff, LPC

_____ Jenny McNees, LICSW

_____ No Preference

## History (if available)

Current Medical and/or Psychiatric Diagnoses:

______________________________________________________________________

______________________________________________________________________

______________________________________________________________________

List of Current Medications: (if ADD/ADHD, please list failed medications):

______________________________________________________________________

______________________________________________________________________

______________________________________________________________________

**PLEASE ATTACH SIGNED ROI, MEDICAL RECORDS, AND INSURANCE INFO**