IMPACT GROUP
BEHAVIOURAL HEALTH SERVICES

9428 Brookline Ave.STE 2 | Baton Rouge, LA 70809
Phone: 225-372-2693 Fax: 225-372-2693
Email: contact@impactgbhs.com

REFERRAL FOR OUTPATIENT THERAPY

Date of Referral: _____ Referral By / Phone: _____ - _____ - _____
Reason for Counseling Referral _____
_____
_____

☐ Psychiatric Evaluation requested

Doctor/Psychiatrist: _____ Phone: _____ - _____ - _____
Other Professional/Role: _____ Phone: _____ - _____ - _____

REFERRAL CLIENT INFORMATION

☐ Adult ☐ Child Prefers: ☐ In-home appt. ☐ In-School appt.

First Name: _____ Last Name: _____ MI: _____

DOB: _____ - _____ - _____ Gender: ☐ Male ☐ Female SS#: _____ - _____ - _____

Home Address: _____ _____ __ City: _____ Zip Code: _____

Phone: _____ - _____ - _____ Alternate Phone: _____ - _____ - _____ Cellular: _____ - _____ - _____

For Children Only (please complete the following):

Parent or Guardian name(s) / Relationship: _____

Phone: _____ - _____ - _____ Alternate Phone: _____ - _____ - _____

Address (if different from child's): _____

INSURANCE INFORMATION

For Medicaid Referrals, (please include the following):

Provider ID #: _____ Provider NPI: _____

☐ Check if no insurance

Insurance Provider: _____ Member Insurance: _____

Policy holder: _____ Relationship to client: _____

Please fax referrals to Impact Group BHS at (225)-372-2693