Abelard PSYCHOTHERAPY, INC.

Referral Form – fax to **781-344-0027**, ATTN: Intake
(p) 781-344-0057
450 Pearl Street, Suite 3 & 3B, Stoughton, MA 02072
30 Eastbrook Road, Suite 103, Dedham, MA 02026

Referring Agency/Office / Clinician Information

Name of referring Agency_____**Todays Date:** _____

Agency/facility fax number _____Phone contact number_____

Name of clinician completing form _____Agency/facilty address_____

Referred Client/Patient Information

First name_____ Client last name _____DOB _____Age_____

Home address_____ City _____Zip code_____

Cell phone #_____ (voicemail ok? Y N) Alternate phone # _____ (voicemail ok? Y N)

Prim. Insurance Name _____ Member ID #_____ Ins. Provider/BH phone #_____

Second. Insurance Name _____ Member ID #_____ Ins. Provider/BH phone #_____

Insurance subscriber name _____ Subscriber D.O.B:_____

PCP Name & Contact # _____ Client Ethnicity/Race _____

Email address_____ (for appointment reminders)

Reason for Referral / Services Requested

Medication Management Y N Therapy Y N Both therapy and medication management Y N

Current therapist name_____(if applicable) Phone number _____

Primary mental health diagnosis(es)/challenges_____

Medical issues Y N _____

Substance abuse/Alcohol issues (past or present) Y N_____ Cigarettes (ppd)_____

Social issues and/or legal involvement (i.e. DCF, open court cases, court mandated tx, etc.) Y N _____

_____

Current Medication Regimen

Who was your last prescriber? _____ Why did you d/c tx with them? _____

Drug name	Dose	Instructions	Reason	Efficacy

Patient consents to release personal health information to Abelard Psychotherapy, Inc.

Name_____ Signature_____ Date_____

Abelard Psychotherapy, Inc. – office use ONLY:

Insurance coverage: Plan year: Deductible Y N
visits per year: Client Availability: Auth#:
Appointment scheduled for: