Appointment Date & Time: \_\_\_\_\_\_\_\_\_\_\_\_\_ Location: \_\_\_\_\_\_\_\_\_\_\_ Therapist: \_\_\_\_\_\_\_\_\_\_\_\_ Fiscal: Y or N

Client ID: Insurance Type: Date Verified:

Co-Pay: Amount: $ Deductible: \_\_\_\_\_\_\_\_\_\_ Amount $ \_\_\_\_\_\_\_\_\_\_ Initials:

 

20231 Paint Boulevard 850 Leonard Street

Shippenville, PA 16254 Clearfield, PA 16830

(814) 226-1159 (814) 205-4004

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VICTIM REFERRAL FORM

Today’s Date:

Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date of Birth: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Address: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Phone Number: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

 \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

 \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Gender: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

If juvenile, list parent/caregiver’s names and addresses:

List other individuals residing in household:

List police or agencies involved with individual:

List any observable impact of alleged abuse (home/school behavior, nightmares, bedwetting, etc.)

Perpetrator’s Name: Phone Number:

Address: Relationship to Victim:

Do the parents/caregivers believe and support the victim?: \_\_\_\_\_\_ Yes \_\_\_\_\_\_ No

Explain:

Have charges been filed?: \_\_\_\_\_\_ Yes \_\_\_\_\_\_ No

If yes, list officer and police agency:

Does the victim have Medical Assistance?: \_\_\_\_ Yes \_\_\_\_ No

MA Number: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ County where issued: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Social Security Number: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Does the victim have any other insurance coverage: \_\_\_\_ Yes \_\_\_\_ No

If so, list the name of insurance and numbers:

Who is responsible for the payment of services (client, agency, etc.)

Which service are you requesting?:

 \_\_\_\_\_\_ Yes \_\_\_\_\_\_ No Evaluation (including interview, possible testing and report)

 \_\_\_\_\_\_ Yes \_\_\_\_\_\_ No Ongoing Treatment

Does your agency need the evaluation completed by a certain date (Ex.-upcoming court hearing)?: \_\_\_ Yes \_\_\_ No

If yes, due date of completed evaluation: \_\_\_\_\_\_\_\_\_\_\_\_\_\_

Referral Source Information:

Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Agency: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Phone:

Address: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Fax:

 \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_