REFERRAL INFORMATION

INSTRUCTIONS

Please complete as much information as you have available. Basic contact information is acceptable. Please fax this form to (406) 782-1318 or mail this form to 2510 Continental Drive, Butte, MT 59701. We will contact the parties listed to schedule an appointment. If this is an urgent referral, please call (406) 782-4778 to schedule an appointment and indicate its urgency. Please follow-up the phone call by sending this completed form to our office either by fax or mail. We can usually accommodate urgent referrals the same day or within 24 hours.
Thank you for choosing Compass Professional Services LLC!

SOURCE OF REFERRAL

Date _______/_______/_______

Name ____

Company/Organization ____

Address ____ City ____________________ State _________ Zip ______________

Phone No. (Office) (_____) ___________________ (Fax) (_____) ___________________ (Other) (_____) ____________________

E-Mail Address: ____

Relationship: Medical Provider ☐ Case Manager ☐ Therapist ☐ Attorney ☐ Other Professional ☐ *specify:* ________________________

SERVICES REQUESTED

☐ Mental health evaluation
Specify: Child ☐ Adolescent ☐ Adult ☐
Rule-Out (if applicable): _________________________________

☐ Psychotherapy
Specify: Individual ☐ Couples ☐ Family ☐ Group ☐

☐ Substance abuse/addiction evaluation and interpretation of results
☐ Psychological testing and interpretation of results
☐ Psychosexual evaluation and interpretation of results
☐ Family systems evaluation and interpretation of results
☐ Child custody evaluation and interpretation of results
☐ Clinical supervision and consultation with professional
☐ Evaluation of treatment records, in consultation with professional
☐ Guardian ad litem services for a minor child
☐ Other services ____

CLIENT INFORMATION

Client Name (First) _________________________ (MI) ____ (Last) __________________________________ Marital Status ____________

Address ____ City ____________________ State _________ Zip ______________

Phone No. (Home) (_____) ___________________ (Work) (_____) ___________________ (Cell) (_____) ____________________

Sex: F ☐ M ☐ Age __________ Date of Birth _______/_______/_______

Payment Source: Insurance ☐ EAP ☐ Self-Pay ☐ Insurance Name ____

Reason for Referral ____
____

PARENT/LEGAL GUARDIAN INFORMATION OR PARTNER INFORMATION

if client is a minor or client is referred for couples therapy

Name (First) _________________________ (MI) ____ (Last) __________________________________ Marital Status ________________

Address ____ City ____________________ State _________ Zip ______________

Phone No. (Home) (_____) ___________________ (Work) (_____) ___________________ (Cell) (_____) ____________________

Sex: F ☐ M ☐ Age __________ Date of Birth _______/_______/_______

Relationship: Spouse ☐ Parent/Legal Guardian ☐ Other ☐ *specify:* ____

OFFICE USE ONLY

Contact with Referral: _____/_____/_____ (Date) Contact Made / Voicemail Msg / No Answer _____/_____/_____ (Date) Contact Made / Voicemail Msg / No Answer _____/_____/_____ (Date) Contact Made / Voicemail Msg / No Answer

Appointment Scheduled: No ☐ Yes ☐ *If yes,* _____/_____/_____ (Date) at ____:______ (Time) AM PM Packet Mailed? ☐