Crossroads Counseling Center

The Crossroads Counseling Center
909 Main St. Suite 505
Dubuque, IA 52001
Phone: (563) 556-0699
Fax: (563) 583-3077
e-mail: info@crossroadsdbq.com

FILL THIS OUT Give COPY to Yvette (Assignment) and than to Lori.

REFERRAL FORM

Date of Referral:_____

DEMOGRAPHIC INFORMATION

Client Name _____ Client SSN: _____

Birth Date: _____ Age: _____ Gender: □ Female □ Male

Address: _____ City, State, Zip: _____

Home Phone: (_____) _____

IF CLIENT IS A MINOR:

Mother: _____ Father: _____

Address: _____ Address: _____

Home #: _____ Home #: _____

Other #: _____ Other #: _____

E-mail: _____ E-mail: _____

INSURANCE & MEDICAL INFORMATION

Insurance Company: _____

INSURANCE company policy number_____

SUBSCRIBER's name_____

Copay: _____ Deductible: _____

No. of Sessions: _____ Autho. Needed? Y or N Authorization #:_____

Misc:_____

REFERRAL AND COLLATERAL INFORMATION

Referral Source: _____ Phone number: _____

Services requested: _____

Specific clinician requested? _____

Reason for Referral: _____

_____

_____