MOUNTAINEER
PSYCHOLOGICAL SERVICES

Therapy Referral Form

Date: _____/_____/_____

Patient Name: _____

Date of Birth: _____/_____/_____ Sex: M / F Age: _____ SSN:_____

Referred by: _____ Relation to Patient:_____

Referral contact info: (____) _____ Fax:_____

Email:_____

Patient Mailing address:_____

_____

Patient Telephone Number: _____ Is this a mobile / home / work line?

Patient Email: _____

<u>Billing Information:</u>

Primary Insurance Carrier:_____

Insurance Company Contact Number: _____

Policy Number: _____

Group Number:_____

Policy Holder's Name, Date of Birth, and Social Security number, Relation to Patient:

_____

Secondary Insurance? Y / N: _____

Please briefly describe presenting concern(s):

_____

_____

_____

4000 Coombs Farm Drive
Building D, Unit 102
Morgantown, WV 26508
304-241-1766 /304 381-2648 (fax)

105 North Wedge Street
Bridgeport, WV 26330
(304) 241-1766
fax (855) 898-5805

Has the patient ever talked with a psychiatrist, psychologist, or other mental health professional? YES NO
(Please list approximate dates and reasons): _____

_____

_____

Is the patient being treated by any mental health professional or taking any psychiatric medications now?
YES NO :

_____

_____

Has patient been hospitalized for mental health reasons? (If yes, please list approximate dates and reasons):

_____

_____

Has the patient ever had a psychological evaluation? (If yes, please list approximate dates and reasons):

_____

_____

Does the patient have any significant medical issues? Describe:

_____

_____

How did you hear about our clinic?_____

Preferred Location: _____Morgantown _____ Bridgeport _____Any

Clinician Requested: ____Jennifer Myers, PhD; _____ Jessica Matala, LICSW; _____Stacey Crandall, LPC
_____Ron Satterfield, LCSW; _____Amy Zeiders, LICSW; _____Alissa Gen, LICSW; _____Darcie Yerkovich, LGSW
_____Carly Wears, LGSW; _____Jennifer Adams, LPC

_____No Preference/First Available

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