SEASONS
counseling of michiana

REFERRAL FORM

Patient Name: _____ **DOB:** _____

If Patient is a Minor, **Guardian Name:** _____

Phone Number: _____ **Insurance:** _____

Home Address: _____

Referring Professional: _____

Specialty: _____ Group/Practice: _____

Contact Person: _____ **Phone:** _____

Reason(s) for Referral: _____

_____

Notes: _____

_____

Please fax completed form to: Seasons Counseling of Michiana - Client Specialist, **(574) 271-7202**

Internal Use Only Date Received: _____

Contact Notes: _____

_____

First Appointment: _____ Clinician: _____

We are here to help.

17195 Cleveland Road, South Bend, IN 46635 | www.seasons-counseling.org | P: (574) 277-0274 | F: (574) 271-7202