Tru-Rob Counseling and Consulting LLC

Therapy Referral Form

Date ________________________

How Did you hear about us? Internet Search________ Referral________

What Search Engine or Site? (if applicable)____

Referral Source: (i.e. Friend or Family)____

Were you referred by a church? If so, please list ____

Type of Visit Requested: In-Person _________ Virtual ________ No preference _________

Under the age of 18? Yes ____ No_____

Personal Information

Name: ____________________________________

Gender: Male ______ Female _______ Other ____________

DOB: ______________________

Age: __________ Marital Status: ____________________ Occupation: ____________________________

Employment Status (please circle) Employed FT Employed PT Unemployed Full Time Student

Address: ___________________________ City: _____________ State: _______ Zip: ___________________

Phone: (_____) ____________________________

Email Address: ____

Insurance Information

Insurance Carrier: _________________________________

Member ID: ____________________

Group ID: __________________________

Subscriber/Person Responsible for Payment Name: _______________________

Subscriber/Person Responsible for Payment DOB: ____

Relationship (i.e. Client or Parent/Guardian): ____

Subscriber/Person Responsible for Payment Address:

____

Counselor Gender Preference: Female _______ Male _______

Are we permitted to TEXT you? Yes ___ NO____

Copies of all insurance cards (FRONT AND BACK) and driver's license or picture ID (FRONT ONLY)

Tru-Rob Counseling and Consulting LLC

Availability:

- ☐ **Monday ____________________**
- ☐ **Tuesday ____________________**
- ☐ **Wednesday _________________**
- ☐ **Thursday ___________________**
- ☐ **Friday ______________________**

Parent Information if Client is a minor

Name: ____________________________________

Gender: Male ______ Female _______ Other ____________

DOB: _____________________

Age: __________

Address: __________________________ City: _____________ State: _______ Zip: __________________

Phone: (_____) ___________________________

Email Address: ____

Check If Client is using EAP

- ☐ Health Advocate
- ☐ Optum
- ☐ Carebridge
- ☐ FaithLink
- ☐ Lyra

Authorization Code ________________________ Number of sessions ________

Reason for Referral

____

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If you completed this referral form online please send referral form to Skyler.Trudell@tru-rob.com

Copies of all insurance cards (FRONT AND BACK) and driver's license or picture ID (FRONT ONLY)