DIVINE INTERVENTION REHABILITATION, LLC

New Client Referral Form

Client Information:

Name: (Last, First, MI) _____

Address: _____ City: _____ State: _____ Zip: _____

Telephone: _____ Email: _____

DOB: _____ SSN: _____ Marital Status:_____

Parent/Legal Guardian Name (If Applicable):_____

School Name (If Applicable): _____ Grade:_____

Currently Receiving Services: ☐Yes ☐No If yes, list agency name(s) _____

Medication(s): _____ Preferred Language_____

Presenting Issues To Be Addressed:

☐ Anger Management ☐ Family Relationships ☐ Depression ☐ Grief/Loss

☐ Stress Management ☐ School Behavior ☐ Attendance/Truancy

Other: _____

Insurance Information:

Insurance Company: ☐ Aetna ☐ Amerigroup ☐ Amerihealth Caritas

☐ LA Healthcare Connections ☐ United Healthcare/Optum

☐ Private Insurance

Name of Insured (if other than client): _____

Insured's DOB: _____ Insured's SSN: _____

Insurance ID #: _____ Group #: _____

Referral Information: Please describe recent occurrences and/or incidents

_____

_____

_____

Referral Source: ☐Self ☐Parent/Guardian ☐DCFS ☐FINS ☑Other

Name: _____ Telephone: _____ Fax: _____

Address: _____

Office Use Only:

Appt Date: _____ Appt Time: _____ ☐Show ☐No Show

☐Assessment ☐ Individual Psychotherapy ☐Family Psychotherapy ☐Parenting

Fax Completed form to (504) 263-2900 or (504) 263-2821