LIFESPAN CARE INC.

Name of Person Making Referral: _____ Date: _____

Type of Service: ☐ Assessment/Screening ☐ Medication Management ☐ IT/FT/Group Therapy

Phone #: _____ Email: _____

Last Name: _____First Name: _____ Middle In. ____ DOB: _____ Sex: ___

Address: _____ City: _____ State: _____

Zip Code: _____ Phone #: _____ Social Security #: _____

Primary Language: _____ Race: _____ Ethnicity: _____

Primary Payment Source: ☐ Medicaid #: _____☐ Other Insurance ☐ Self-Pay

Other Insurance/Self-Pay Details: _____

Parent/Legal Guardian (If Applicable): _____ Phone #: _____

Address (If different from above): _____

City: _____ State: ___ Zip Code: _____ Primary Language: _____

Brief History/Presenting Problem: _____

_____

_____

_____

Check All That Apply:

☐ Dangerous Behaviors ☐ Substance Use/Abuse ☐ Thoughts of Suicide/Homicide

☐ Problems at School ☐ Family Problems ☐ History of Abuse/Neglect

Primary Care Office Name: _____ Physician: _____

Address: _____ Phone #: _____

Allergies: _____Medication(s)/Medical Issues: _____

_____

Signature of Person Making Referral: _____ Date: _____

Please Email/Fax this completed referral form to kdixon@lifespancare.net or 843-663-0749.