MILESTONES
CLINICAL & HEALTH RESOURCES

External Referral Form - Therapy Only

Date: _____

Referring Provider's Name: _____

Referring Provider's Phone: _____

Client Demographic Information

DOB: _____ Circle One: Female Male Non-Binary Declined

Client Name: _____ SSN: _____

Phone #: _____ Alt Phone: _____

Address: _____

Insurance Type/Name: _____ Insurance ID: _____

Current Clinical/Medical Information

Primary Care Physician: _____ Phone: _____

Previous Therapist: _____ Phone: _____

Reason for Referral

_____

_____

_____

_____

Current Diagnosis List

_____

_____

_____

_____

Please have client sign a Release of Information for current/past therapist and send with completed referral form.

Milestones Clinical & Health Resources

550 South Adams Street 47403
Phone: 812-333-6324 Fax: 812-331-6700