☐ **Kissimme**
111 E. Monument Ave
Kissimmee, F 34741
Phone: (863) 763-8900

☐ **Okeechobee**
203 SE 2nd Ave
Okeechobee, F 34974
Phone: (863) 261-8900

Fax: 1-863-279 -1156
E-Mail: Susana@CTcentercares.com

Referral Form

Client Information (Please print): ***Date of Referral:*** __________

Last Name: ______________________ First Name: __________________________ Middle Initial: _________

SSN: ______________ Sex: M ☐ F ☐ DOB: __________ Race: ______________

County: ______________ Home Address: __________________________ City: __________________________

Zip: ________ Parent/Guardian: ____

Phone: __________________________ Work: __________________ Cell: _______________

Bilingual Needed: ☐ Yes ☐ No ___________________

School: ____ Grade: _________ ESE: ☐ Yes ☐ No

List of Medication(s): ____

Current Treatment:

Previous Treatment:

Primary Reason for Referral: (e.g. School Anxiety, Depression, Bullying, Noncompliance, Stealing, Substance, Abuse, Trauma, Verbal Aggression, etc.)

Services Required: (e.g. Individual Therapy, Group Therapy, Case Management, Mentoring, Psychiatric Evaluation, etc.)

Please list ALL insurance coverage for the client being referred:

Funding Information (Check all that apply)		Insurance ID #	Therapist	
Medicaid			COMMENTS:	
United Healthcare				
BCBS				
TANF				
Other (Specify)				
NO INSURANCE (May be eligible for FSPT)				
Self-Pay				

I understand that I must disclose all insurance coverage. If failure to disclose results in a denied claim, I will be financially responsible. ____________________________________ (Signature of parent/caregiver)

Referral Source Information: (Please Print)

Name: ______________________ Agency: ______________________

Email: ______________________ Phone: ______________________

Fax: ______________________ Requested Therapist: ______________________

This information has been disclosed to you from records whose confidentiality is protected by state law. State law prohibits you from making any further disclosure of such information without the specific written consent of the person to whom such information pertains, or as otherwise permitted by state law. A general authorization for the release of medical or other information is NOT sufficient for this purpose.

Confidential & Privileged Information for Professional Use Only