WPCS WESTERN PSYCHOLOGICAL & COUNSELING SERVICES, P.C.

School Based Program Referral to Western

Student's first name: ____________________ **MI:** ___ **Last Name:**______________________

DOB:______/______/_________ **Age:**___ **Gender:**___________

Referred by:____ **Date of Referral:**_________________

Reason for Referral: ☐ **adjustment issues** ☐ **aggression/fights** ☐ **anxiety/worry**

☐ **alcohol/drug use** ☐ **eating problems** ☐ **sadness/depression** ☐ **self-harm behaviors**

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Provider :____

Contact Information

Parent/Guardian: ______________________________ ☐ Mother☐ Father Other: _______________

Parent/Guardian Phone: ______________________ ☐ Cell☐ Work☐ Home

Mailing Address: ____________________ ____

Insurance information

Health Insurance Company (on health plan card): ____

Subscriber Name: ___________________________ **Subscriber DOB:** ____________________________

Health Plan ID #: __________________________ **Group/Policy ID**: _________________________

Secondary Health Insurance Company (if applicable): ____

Subscriber Name: ____________________________ Health Plan ID #: __________________________

Group/Policy ID: _________________________

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