PLEASE PRINT

FLORIDA
Therapy Services, Inc.

Florida Therapy Services Referral Form

Centralized Referrals Department

850-215-1946 877-234-5351

FAX: 850-215-1942 Email: referrals@flatherapy.com

Date of referral: _____ Client Insurance Information:

Insurance type: _____ ☐ Medicaid ☐ Medicare ☐ Third Party ☐ Self-Pay

Primary Insurance #: _____ Secondary Insurance #: _____

Client Name: _____ DOB: _____ Gender: _____ SSN: _____

Client Contact Information: Phone: (primary) _____ (secondary) _____

Address: _____ County: _____
Street City State Zip

Leave message? ☐ No ☐ Yes: _____ Email Address: _____

For minors, legal guardian(s) name/relationship: _____

- ✓ Legal documents supporting guardianship/ POA? ☐ N/A ☐ No ☐ Yes: _____
- ✓ Any other legal guardians? ☐ N/A ☐ No ☐ Yes: _____
- ✓ Specific custody agreements? _____
- ✓ School: _____ County: _____ Grade: _____ ESE? ☐ No ☐ Yes
  IEP? ☐ No ☐ Yes

Referred by: _____ Referral Address: _____ _____

Referral Phone: _____ FAX: _____ Email: _____

- ✓ Do you wish to be updated on the status of this referral? ☐ No ☐ Yes
- ✓ Do you have any specific requests regarding this referral? ☐ No ☐ Yes
- ✓ *If yes, explain:* _____

Reason for referral: _____

Is the client reporting that they are a danger to themselves or others? ☐ No ☐ Yes

- ✓ *If yes, explain:* _____

Substance abuse issues/ concerns reported? ☐ No ☐ Yes

- ✓ *If yes, explain:* _____

Has the client received mental health services at FTS or elsewhere in the past? ☐ No ☐ Yes

- ✓ *If yes, when and where:* _____
- ✓ *Previous diagnosis?* _____