WISE Program

Referral Form

Referral Date

Demographic Information

****Referral can not be processed without all Insurance information included**

Client Name:			
Address		Client Email:	
Phone Number		*Date of Birth*	
Insurance Name And ID Number ***Please include copies of insurance cards if possible***		*Name and DOB of policy holder*	
Secondary Insurance		*ID Number*	
Name and number of Client's ***legal guardian (if applicable)***		*Name and number of emergency contact*	
Primary Diagnosis or ICD Code		*Secondary Diagnosis or ICD Code*	
Primary Care (or referring) Doctor		*Phone Number:*	

Please list family members residing in household (If applicable)

Name of Family Member	*DOB*	*Insurance/ID #*	*Relationship to Client*

Current/Past Services

Name of Client	*Program*	*AgencyProvider*

Is the client looking for services in-home or virtually through Telehealth?

If in-home is not available as an option is the client able to do Telehealth?

If yes, what is the client's email?

Reason for Referral:

Do you have any safety concerns?

Referral Source Information

Name		*Agency*	
Office Ph		*Cell Ph*	
Email			

Please send referral to

Courtney DeLauri, Director of Community Based Programs

Email: courtney@stokescounseling.com

Fax: 203-632-5190

Questions? Call 203-729-0341