New Client Referral Form

CLIENT INFORMATION

TODAY'S DATE: _____

FIRST NAME: _____ MIDDLE INITAL: _____ LAST NAME: _____

ADDRESS: _____

HOME/CELL PHONE: _____ WORK PHONE: _____

BIRTHDATE: _____ SEX: _____ AGE: _____

ADDRESS: _____

SCHOOL ATTENDED: _____ GRADE: _____

FAMILY INFORMATION

PARENT/SPOUSE/GUARDIAN (circle which one) NAME: _____

ADDRESS: _____

HOME/CELL PHONE: _____ WORK PHONE: _____

EMAIL: _____

PRESENTING ISSUES / DIAGNOSIS

_____

_____

_____

_____

REFERRING ORGANIZATION

ORGANIZATION: _____ CONTACT PERSON: _____

PHONE: _____ EMAIL: _____

WHAT TEC SERVICES ARE YOU INTERESTED IN? (CHECK ALL THAT APPLY)

❑ Equine Assisted Psychotherapy (EAP) ❑ Youth Mentoring ❑ Veterans Therapy

❑ Therapeutic Riding ❑ Youth EAP Groups ❑ Other

HOW WILL THESE SERVICES BE PAID FOR? (CHECK ONE)

❑ WPS ❑ IRIS ❑ County ❑ LSS

If the assessment/services are funded through the Children's Waiver (WPS), we need the Authorizations on or before the day of assessment and before services are rendered.

Assessment Authorization must be for the date of the assessment appointment only and in the amount of $150.
Ongoing Services Authorization must have all pertinent information, including the start/end date of authorization, the appropriate service codes, definition of unit, unit rates and number of approved units.

BILLING AGENCY'S INFORMATION:

NAME OF AGENCY: _____

ADDRESS: _____

CONTACT PERSON: _____