DIVINEINTERVENTION REHABILITATION, LLC

New Client Referral Form

Client Information:

Name: (First, Middle Initial, Last) _____ Date:_____

Address:_____City:_____State: **LA** Zip:_____

Telephone:_____Email:_____

DOB:_____ SSN:_____Marital Status:_____ Language Spoken:_____

Parent/Legal Guardian Name (If Applicable):_____

School Name (If Applicable): _____

Grade:_____Currently Receiving Services: Yes ☐ No ☐

If yes, list agency name(s) _____

Employed: ☐Yes ☐No Where?_____

List of Medication(s):_____

Presenting Issues To Be Addressed:

☐ Anger Management ☐ Family Relationships ☐ Depression ☐ Grief/Loss

☐ Stress Management ☐ School Behavior ☐ Attendance/Truancy

Other: _____

Insurance Information:

Insurance Company: ☐ Aetna ☐ Healthy Blue ☐ AmeriHealth Caritas
☐ Healthcare/Optum ☐ Humana Healthy Horizon
☐ Louisiana Healthcare Connection ☐ Private Insurance

MCO ID #:_____Medicaid#:_____

Referral Information: Please describe recent occurrences and/or incidents

_____

_____

_____

Referral Source: ☐ Self ☐ Parent/Guardian ☐ DCFS ☐ FINS ☐ Other

Name:_____Telephone:_____Fax:_____

Address:_____

Office Use Only:

Appt Date:_____Appt Time: _____ ☐ Show ☐ No Show

Intake/Assessment ☑

Fax Completed form to (504) 263-2900 or (504) 263-2821