Referral for Services

Referring provider information:

Name of provider: _____
Phone: _____ Email: _____
Reason for referral: _____
_____
_____

Client information:

Name: _____ DOB: _____
Phone: _____ Email: _____
Address: _____

Language: ☐ Spanish ☐ English ☐ Both
Therapy: ☐ Virtual ☐ In person ☐ Both

Insurance type:
☐ Aetna ☐ Anthem ☐ Cigna ☐ Optum ☐ Medicaid
☐ Private Pay ☐ Other: _____

Currently in treatment? ☐ Yes ☐ No
Previous Mental Health History? _____
_____

Current medications: _____
Primary care provider: _____
Legal issues: ☐ Currently on probation ☐ Active Lawsuit
☐ None ☐ History of legal issues ☐ Other: _____
Substance history: ☐ Alcohol ☐ Substances: _____
☐ None Frequency: _____ Frequency: _____

Briefly explain the symptoms: _____
_____

Emergency Contact / Legal Representative

Name: _____
Phone: _____ Email: _____
Relationship to client: _____
Are you the policyholder? ☐ Yes ☐ No
If yes, include a copy of your ID and insurance card as well

A copy or photo of any form of ID and the health insurance card must accompany this referral form. By completing this referral form, you authorize JSB Wellness to contact the client or legal representative via phone, email, or mail.

Email this form and copies to dr.jomary@jsbwellnessllc.com