Nexus-FACTS
FAMILY HEALING

Referral Form

Client Information

Client Legal First & Last Name: ______________________________________ Preferred Name: ____

DOB: ______________________ Client Address: ____ City: ______________________

State: ___________ Zip: _______________County: ______________________ Home Phone: ___________________ Cell Phone: _________________

Email Address: ____

If client is an adult, what is the preferred method of contact? ☐ Phone ☐ Text ☐ Email

Client Gender: ☐ Male ☐Female ☐ non-binary ☐ Transgender ☐ Prefer not to say ☐ Other _________________________________

What pronouns does the client prefer? ____

Give a brief description why the client is seeking services. What is the reason for the referral at this time?

____

How did you hear about Nexus-FACTS?

- ☐ Medical Provider
- ☐ School
- ☐ County worker
- ☐ Web or social media
- ☐ Friend, family, word of mouth
- ☐ Other _______________________

If Client is a minor, please fill out contact information below.

Primary Contact Name: ________________________________

Relation to client: ______________________________________

Address: ☐ Same address as client ☐ Different address

City/State/zip: ____

Phone: ____

E-mail: ____

Preferred method of contact: ☐ Phone ☐ Text ☐ Email

Additional Contact Name: ______________________________

Relation to client: ______________________________________

Address: ☐ Same address as client ☐ Different address

City/State/zip____

Phone: ____

E-mail: ____

Preferred method of contact: ☐ Phone ☐ Text ☐ Email

Who is the legal guardian authorized to sign paperwork?
☐ Same as Primary Contact Above ☐ Same as Additional Contact Above ☐ Other

Legal Guardian Name: ____

Phone: _____________________ E-mail: _____________________________________

Anything to note regarding parental status, legal guardians, custody, etc.:

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Preferences (choose all options that apply)

Therapist gender: ☐ Male ☐ Female

Service Location: ☐ Telehealth ☐ In-Home ☐ In Office

Service type: ☐ Family ☐ Couple ☐ Individual ☐ Psychological Testing ☐ Group ☐ Other _____

Appt hours: ☐ Morning ☐ Afternoon ☐ Evening

Do you have any language needs such as an interpreter? ☐ No ☐ Yes

If yes, describe ____

*Are you open to working with interns? ☐ Yes ☐ No ☐ Maybe, I need more information

If you are a referral agency or professional, please complete the following. (Yes/No)

Referral Agency/Name: ____

Referral Email: ____

Referral Phone: ____

Fax: ____

Date of last DA: ____

Insurance Information

Client is uninsured: Yes ☐ No ☐

☐ Client will be paying out of pocket

☐ Client would like to discuss financial assistance options.

Primary Insurance Coverage

Insurance Name: ____

Insurance Group/Account #: _____________________________

Policy/Individual/Member#: _____________________________

Insurance company phone #: _____________________________

Name of Policy Holder: _________________________________

Relationship to Policy Holder: ☐ Self ☐ Spouse ☐ Child ☐ Other: _______

Policy Holder DOB: ____________________________

Policy Holder Address: _____________

Policy Holder City/State/Zip: _______________________________

Secondary Insurance Coverage

Insurance Name: ____

Insurance Group/Account #: _____________________________

Policy/Individual/Member#: _____________________________

Insurance company phone #: _____________________________

Name of Policy Holder: _______________________________

Relationship to Policy Holder: ☐ Self ☐ Spouse ☐ Child ☐ Other: _______

Policy Holder DOB: ____________________________

Policy Holder Address: ___________________________

Policy Holder City/State/Zip: _______________________