812 W. 8th Street, Suite 6A • Plainview, Texas 79072 • Phone: 806-429-8088 • Fax: 888-296-5176 • www.waypointscounselingpllc.com

THERAPY SERVICES REFERRAL FORM

Referral Date:_____________ Referral Phone:____________________ Referral Fax:______________________

Referral Source:____

Referral Address: ____

Client Name:______________________________ DOB: _______________________________ Gender: ☐ Male ☐ Female

Parent/Guardian Name if Client is a minor:____

Address: ____

Home Phone:_____________________ Cell Phone:______________________ Email: __________________________________

Permission for Waypoints Counseling, PLLC to: Text Appointment Reminders Call/Leave Message Email Intake Packet

Emergency Contact: Name/Relationship:____ Phone number: ______________________

Have you ever been treated by a therapist, counselor, psychologist or psychiatrist? ☐Yes ☐No

Provider(s) and approximate dates:

_________________	_________	_________________	_________
Name	Dates (from-to)	Name	Dates (from-to)
_________________	_________	_________________	_________
Name	Dates (from-to)	Name	Dates (from-to)

Presenting Concerns/Comments (attach additional sheets if necessary):____

____

____

Diagnosis (if known):______________________________________

Diagnosis Report Included? ☐ Yes ☐ No

Medical Records Included? ☐ Yes ☐ No

Copy of Insurance Card Included? ☐ Yes ☐ No

Verified Eligibility & Benefits? ☐ Yes ☐ No

Referral Services Requested (check all that apply):

Psychiatric Diagnostic Assessment Individual Therapy Family Therapy