Crossroads
COUNSELING CENTER

# Adult Referral

Doctor's Office: ______________________________________ Date: ______________

Name: ______________________________________________ DOB: ______________

Address: ____________________________________________________________

Phone Number(s): ____________________________________________________

Insurance: ___________________________________________

Insurance Policy Number: _______________________________

Medicaid Number (if applicable): _____________________________________

Current Significant Issues: _______________________________________________________
______________________________________________________________________________
______________________________________________________________________________
______________________________________________________________________________

Service you are requesting:

- ☐ Counseling/Therapy
- ☐ Psychological Evaluation (please specify)
  - o IQ
  - o Mood Disturbance
  - o Autism Spectrum
  - o Personality
  - o ADHD* vs. _______________________________
    *Medicaid will no longer pay for testing if the only diagnostic question is ADHD. If client has Medicaid, please note the differential diagnosis in consideration. (Ex. ADHD vs. Anxiety, ADHD vs. Mood Disorder, etc.)
- ☐ Other: _______________________________________

Nurse/Physician/PA making referral: ________________________________________________

Phone #: _________________________



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