Martin Muir
COUNSELING

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Client Name:		**Date of Referral:**	
Date Contacted:		**Date of Appt:**	

REFERRAL SOURCE:

Name:	
Relation to client:	
Contact information:	

CLIENT INFORMATION:

Client DOB *(MM/DD/YYYY)*:	
Client SSN *(required)*:	
Client Medicaid Number *(required)*:	
Guardian Name *(if client is a minor)*:	
Client Address:	
Phone:	
Email:	
School:	
Therapist Preference:	

MEDICAID PROVIDER *(check one)*:

☐ **PASSPORT** ☐ **HUMANA CARESOURCE** ☐ **WELLCARE** ☐ **ANTHEM**

REQUESTED SERVICE(S) check all that apply

☐ **SCHOOL-BASED THERAPY** ☐ **IN-HOME THERAPY** ☐ **OFFICE BASED THERAPY** ☐ **CASE MANAGEMENT SERVICES (if meets criteria)** ☐ **MEDICATION MANAGEMENT**

CLINICAL INFORMATION:

Diagnosis *(if applicable)*:	
Medications currently prescribed:	

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Presenting Problems: