FLORIDA
*Therapy Services, Inc.*

# Florida Therapy Services Referral Form

| ☐ *Panama City* | ☐ *Marianna* | ☐ *Tallahassee* | ☐ *Pensacola/Milton* |
|---|---|---|---|
| *850-769-6001* | *850-526-5500* | *850- 681-6001* | *850-471-0017* |
| *Fax 850-769-6003* | *Fax 850-526-5536* | *Fax 850-681-6003* | *Fax 850-471-0009* |

Client Insurance Information: Responsible party: Date of referral:

Insurance type: ☐ Medicaid ☐ Medicare ☐ Third Party ☐ Self-Pay

Primary Insurance #: Secondary Insurance #:

Client Name: DOB: Gender: SSN:

Client Contact Information: Phone: (primary) (secondary)

Address: County:
*Street* *City* *State* *Zip*

Race: Ethnicity: Primary Language:

For minors, legal guardian(s) name/relationship:

- ✓ Legal documents supporting guardianship/ POA? ☐ N/A ☐ No ☐ Yes:
- ✓ Any other legal guardians? ☐ N/A ☐ No ☐ Yes:
- ✓ Specific custody agreements?
- ✓ School: County: Grade: ESE/IEP? ☐ No ☐ Yes

Leave message? ☐ No ☐ Yes:

- ✓ Text? ☐ No ☐ Yes: Email? ☐ No ☐ Yes:

Referred by: FTS staff taking referral:

Referral Phone: FAX: Email:

- ✓ Do you wish to be updated on the status of this referral? ☐ No ☐ Yes
- ✓ Do you have any specific requests regarding this referral? ☐ No ☐ Yes
- ✓ *If yes, explain:*

Reason for referral:

Is the client reporting that they are a danger to themself or others? ☐ No ☐ Yes

- ✓ *If yes, explain:*

Substance abuse issues/ concerns reported? ☐ No ☐ Yes

- ✓ *If yes, explain:*

Has the client received mental health services at FTS or elsewhere in the past? ☐ No ☐ Yes

- ✓ *If yes, when and where:*
- ✓ *Previous diagnosis?*

**FTS Staff Use Only** Notes: