CHENAL
FAMILY THERAPY PLC
ENCOURAGE - EMPOWER - EQUIP

Three Easy Steps to a Seamless Mental Health Referral

1. **Fill out form and fax to 833-226-0134 or scan and send to referrals@ChenalTherapy.com.**
2. **We will make 3 attempts to reach the client (1st attempt will be made within 24hrs of our receiving the fax. 2nd / 3rd attempts will be made within one week.**
3. **We will notify you when/if the client has been scheduled successfully, or if 3 attempts have been made and we were unable to reach the client.**

Referral Source Name: _____

Referral Source Phone #: _____ **Fax #:**_____

Client's Name, as it appears on insurance card: _____

Preferred Name: _____ DOB: _____

Gender (*circle one)*: F / M / Tra SSN: _____ Marital Status: S / M / D / W

Address: _____ City: _____ Zip: _____

Phone: _____ Email: _____

Insurance Company: _____ Subscriber's Name: _____

Subscriber's DOB: _____ Member ID/Policy#: _____ Group#: _____

Type of Services? Psychiatrist / Counselor

Reason for referral: _____

****If the client is a minor, please list as much of guardian's info as you have:**

Name: _____ DOB: _____

Address (if different): _____

Cell Phone #: _____ Home Phone #: _____

Email Address: _____