

*Lux Counseling & Mind
Spa Clinique*

OUTPATIENT THERAPY REFERRAL FORM

Date of Referral: _____

Referral Source: _____ Phone: _____

Patient Name: _____ DOB: _____ Age: _____

Address: _____

Phone Number: _____ Alternate Phone Number: _____

Ok to leave message: Yes No

Ok to leave message: Yes No

Person to be contacted for appointments: _____ Phone: _____

Service Requested: Individual Family Couples Counselor Preference: Male Female None

Presenting Issue: _____

Preference for Appointments: Morning Afternoon Evening None Other: _____

Preference for Appointments: Telehealth Face-to-Face No Preference

INSURANCE INFO

Insurance Carrier: _____ Policy Number: _____

Secondary Insurance: _____ Policy Number: _____

Subscriber Name: _____ Subscriber DOB: _____

Subscriber Address: _____

Additional Comments: _____

Referrals can be faxed to 832-604-7551