The Behavioral Wealth Institute

Professional Referral Form

Please complete the following referral form. All information is kept confidential and handled in compliance with HIPAA guidelines.

Fax completed referrals to: (757) 974-9580

Referring Professional Information

Full Name: ________________________

Title/Role: ________________________

Organization/Practice Name: ________________________

Phone Number: ________________________

Email Address: ________________________

Client/Patient Information

Client Name: ________________________

Date of Birth: ________________________

Parent/Guardian (if minor): ________________________

Phone Number: ________________________

Email Address: ________________________

Reason for Referral (check all that apply):

[ ] Individual Therapy

[ ] Child/Adolescent Therapy

[ ] Couples/Family Therapy

[ ] Group Therapy

[ ] ADHD Testing

[ ] Health Behavior Consultation

[ ] Other: ________________________

Additional Notes / Information:

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Consent

☐ I confirm I have obtained the appropriate consent from the client/patient (or guardian) to share this referral information.

Signature of Referring Professional: ________________________________ Date: _______________