Referral Form~ Fax to 877-855-2504

Please fax this form and we will contact the patient to schedule as soon as possible!

Referring Physician/Provider: _____ Phone:_____

Patient Name: _____ DOB:_____

Patient's Phone:_____ Other Contact Info: _____

Insurance:_____

Please check the box or boxes for type of referral:

❑ Individual Therapy

❑ Family Therapy

❑ Child & Adolescent Therapy

Please check areas you are suggesting assessment or treatment:

❑ General mental health/diagnosis

❑ ADHD/ADD

❑ Mood and personality

❑ Behavioral functioning

❑ Chemical Health/Use

❑ Other: _____

Reason for referral and other information:

_____

_____

_____

_____

The Atrium Building, 1101 W. Clairemont Ave., Suite 1E4, Eau Claire, WI, 54701
♦Phone: 715-602-4321 ♦Fax: 877-855-2504 ♦Website: www.windingriverscounseling.com