LEWC Inc. Adolescent Referral Form **Please DO NOT Email (FAX ONLY) (410) 443-0842**

Date of Referral:	**Consumer's Name:**
Primary Caregiver Name (If different from Consumer):	**Date of Birth:**
Gender:	**School Attending:**
Race/Ethnicity:	**Referrer's Name and Organization:**
Street Address:	**Referrer's Phone #:**
City/State/Zip:	**Referrer's Email Address:**
Consumer's Phone #:	**Referrer's Fax#**

Consent For Referral: (Circle Answers)
As the referring party, I have received written consent to release information from the primary caregiver and/or client to make this referral to Life's Energy Wellness Center Inc. **YES NO**

Additionally, as the referring party, I have included a copy of the signed form by the caregiver and/or client has to release information to Life's Energy Wellness Center Inc. **YES NO**

Insurance Guarantor Information (to whom statements are Sent) Name:	**Referrals Needed/Recommended Service Participation** **(✔ Mark All that apply)**
Address:	_____Prevention Services _____Outpatient Mental Health _____Outpatient Substance Use Disorder Treatment
City: State: Zip:	_____School Based Treatment
Insurance Guarantor Phone Number:	_____Psychiatry/Medication Management
Type of Insurance: Member/Group Number:	_____Psychiatric Rehabilitation Program (PRP)

Has client experienced Any of the following: (Circle Answers)
Physical Abuse: YES NO
Bullying: YES NO
Sexual Abuse: YES NO
Witness to Domestic Violence: YES NO
Emotional Abuse: YES NO
Truancy: Yes No
Parental Incarceration: YES NO
Neglect: YES NO
Victim of Crime: YES NO
Parental Substance Abuse: YES NO
Pregnant: YES NO
SI/HI: YES NO

Reason for seeking Treatment:

_____
_____
_____

Referral Comments:

_____
_____
_____
_____