LEWC Inc. Adult Referral

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:	**Employment Status:**
Race/Ethnicity:	**Last 4 Digits of SSN:**
Street Address:	**Referrer's Name and Organization:**
City/State/Zip:	**Referrer's Phone #:**
Consumer's Phone #:	**Referrer's Address/City/State/Zip:**

Consent For Referral: (Circle Answers)
As the referring party, I have received written consent to release information from the primary caregiver and/or consumer 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 consumer 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:	_____Outpatient Mental Health
City: State: Zip:	_____Outpatient Substance Use Disorder Treatment
Insurance Guarantor Phone #:	_____Psychiatry/Medication Management
Type of Insurance: Member/Group Number:	_____Psychiatric Rehabilitation Program (PRP)

Has consumer experienced Any of the following: (Circle Answers) Physical Abuse: YES NO Bullying: YES NO Sexual Abuse: YES NO Domestic Violence: YES NO Emotional Abuse: YES NO Incarceration: YES NO Neglect: YES NO Victim of Crime: YES NO DWI/DUI: YES NO Pregnant: YES NO SI/HI: YES NO	**Consumers reason for seeking Treatment**: _____ _____ _____ Additional Comments: _____ _____ _____ _____ _____