



LEWC Inc. Adolescent Referral Form

Please DO NOT Email (FAX ONLY) (410) 443-0842

Date of Referral:	Client's Name:
Primary Caregiver(s) Name(s):	Client's Date of Birth:
Gender:	School Attending:
Race/Ethnicity:	Last 4 Digits of Social Security No:
Street Address:	Referrer's Name and Organization:
City/State/Zip:	Referrer's Phone #:
Client'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 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:

Address:

City: **State:** **Zip:**

Insurance Guarantor Phone Number:

Type of Insurance: **Member/Group Number:**

<p>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 Parental Incarceration: YES NO Neglect: YES NO Victim of Crime: YES NO Parental Substance Abuse: YES NO Pregnant: YES NO SI/Hi: YES NO</p>	<p>Reason for seeking Treatment:</p> <hr/> <hr/> <hr/>
	<p>Referral Comments:</p> <hr/> <hr/> <hr/>