Playful Journeys Inc.
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REFERRAL FORM

Please provide as much information as possible.
Please let your patient konw we will contact them within 2 weeks.

Date of referral:		
Patient last name: First: MI:		
Date of birth:	Gender:	
Parent/guardian name:	Best contact phone(s):	
Address:	Insurance Plan:	
	Policy #:	
	Policy holder name:	
Referral Question *Please describe specific problems/symptoms and diagnosis:*	**Category of Request** (check all that apply): ☐ Behavioral Health Counseling ☐ Group/Family Therapy ☐ Psychiatric Medication Management ☐ Play Therapy ☐ Neurofeedback Therapy ☐ EMDR ☐ Other _____	

Previous/current relevant health or mental health history (include duration of symptoms):

ICD-10 Code(s) (for insurance prior authorization):

Does the patient have any of the following limitations: (check)
☐ Communication ☐ Language ☐ Vision ☐ Hearing ☐ Physical Disability ☐ History of Head injury

Requesting provider:	☐ Primary Care Provider ☐ Other _____
Best contact number:	Fax:
Referring Provider Signature: Today's Date:	

*****Please send any recent chart notes, history and physical reports, or discharging summaries.**