1304 Commonwealth Ave
Boston, MA 02134
617-482-5292 (TDD/Voice)
617-482-5232 (Fax)

REFERRAL FORM FOR SERVICES

****** ALL INFORMATION IS REQUIRED IN ORDER TO PROCESS REFERRAL ******

Referral Information

Referral Type ☐ Self-referral ☐ Community Partner

Service Type *(select all that apply)* ☐ **Substance Use Eval. & Counseling**

☐ **Mental Health Services** *(select all that apply)*

○ Anger Management ○ Outpatient Therapy ○ Gambling Evaluation & Treatment ○ Other:

Person Referred for Services

Name *(First, MI, Last)* _____ **DOB** *MM/DD/YYYY* _____ **Last 4 SSN** _____

Mailing Address *(Street or PO Box)* _____ **City, State** _____ **Zip Code** _____

Contact Number _____ **Email** _____

Gender ☐ Female ☐ Male ☐ Non-binary/conforming ☐Trans-female ☐ Trans-male

Preferred Language ☐ English ☐ Other _____ ☐ **Interpreter needed**

Marital Status ☐ Single ☐ Married ☐ Separated ☐ Divorced ☐ Widowed

Emergency Contact Name _____ **Number** _____

History of Presenting Concern: *(Fax/email any additional information that will be helpful for services with this form)*

Payment Information

☐ **Self-Pay:** Intake: $200 + Each individual session: $165.00

We accept payment online or by check. We have sliding scale payment options available.

☐ **Insurance Carrier:** ☐ BCBS ☐ UnitedHealthcare ☐ Tufts ☐ Cenpatico ☐ Cigna ☐ Aetna

☐ MassHealth: ○ MBHP ○ NHP ○ BMC ***Please foward picture of insurance front and back***

Policyholder Name _____ ***DOB*** _____

Mailing Address _____

Relationship ☐ Self ☐ Spouse ☐ Child ☐ Other **Contact #** _____

Policy # _____ **Group #** _____

Effective Date _____ **Co-Pay** _____

**** For Community Partner Referrals ****

Date _____ **Organization** _____

Point of Contact Name _____

Contact Number _____ **Email** _____

Primary Point of Contact for monthly reporting: ☐ **Same as above** ☐ **Not applicable**

Print Name _____

Contact Number _____ **Email** _____

Referral form accepted via scan & email to referral@docwayne.org **or fax (617) 482-5232**