

# REFRAMED COUNSELING

Reframe Your Symptoms. Rediscover Your Strengths. Reimagine Your Future.

## Referral Form | Reframed Counseling

**Name (legal as identified to insurance):**

**Preferred name if different:**

**Gender (legal as identified to insurance):**

**Preferred Gender Identification and pronouns:**

**Date of Birth:**

**Current Address:**

**Legal Guardian:**

**Phone Number:**

**Can we leave a message (yes or no):**

**Email**

**Can we email (yes or no):**

**Person making the referral and relationship to client:**

**Reason for referral (presenting challenges):**

**Any previously known diagnosis:**

**Strengths and interests:**

**Any physical, medical, emotional or cognitive needs important to note prior to intake:**

**Insurance Information:**

- **Insurance Company:**
- **Group #:**
- **Relationship of client to subscriber:**
- **Subscriber name/dob if different then client:**
- **Address of subscriber if different then above:**
- **Phone number for behavioral health benefits (usually found on back of card):**

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