REFERRAL FORM

Fax: 888-587-1421

E-mail: counseling@vvgroup.net

Mail: Visionary Vanguard Group, Inc. 1200 Oakley Seaver Dr., Suite 203; Clermont, FL 34711 OR

1221 W. Colonial Drive; Ste. 202; Orlando, FL 32804

Priority Determination: □ Urgent (3 days) □ Routine (7 days)

DEMOGRAPHIC INFORMATION:

Name:_____ Social Security #:_____

Parents/Caregivers Names:_____ Relationship to Client:_____

Address:_____ County:_____

City/State:_____ Zip:_____ Email:_____

Phone:_____ Gender:_____ Race:_____ DOB:_____ Age: _____

School:_____ Grade: _____

Client's preferred language:_____ Caregiver's preferred language:_____

Referral Source:

Person completing form:_____ Referring Agency:_____

Phone:_____ Fax:_____ Email:_____ Date:_____

Client is currently receiving: ☐In-home / ☐In-school / ☐Individual Therapy / ☐Medication / ☐Other:_____

Therapist Name:_____ Agency:_____ Phone:_____

INSURANCE INFORMATION

Insurance Info: Company_____ Member Number:_____ Group Number_____

Name of Insured:_____

Address for Claims: _____

_____

_____

REASON FOR REFERRAL

SERVICES REQUESTED: ☐**Individual Counseling** ☐**Group Counseling** ☐**Family Counseling** ☐**Targeted Case Management**

Please describe briefly the reason for the referral:

_____

_____

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_____

_____

FOR VVG OFFICE USE ONLY:

☐ Case Accepted/Assigned Date:_____ Counselor: Assigned _____

Case Not Accepted Reason:_____ Date:_____

☐ Case Referred to:_____ Date Referred:_____

Updated; 01/12; 07/15