Child/Adolescent Behavioral Health Therapy Referral Form

Please send this referral form, along with visit note and pictures of insurance cards, to our referral fax (Attn: Referral (855)-492-1625) or email (referral@tidalintegratedhealth.com). Appointment dates will be provided via email.

Patient Info:

Name: _____

DOB: _____

Guardian: _____

Address: _____

_____

Phone Number: _____

Email Address: _____

Provider Info:

Referral Date: _____

Name: _____

Provider NPI: _____

Address: _____

_____

Phone Number: _____

Fax Number: _____

Diagnosis(es) and ICD-10 Code(s):

Reason for Referral (Check all that apply):

- ☐ Teen Acceptance and Commitment Therapy (ACT) Group
- ☐ Behavior Management Therapy
- ☐ Cognitive Behavior Therapy

Treatment(s) Requested (Check all that apply):

- ☐ Adolescent/Child Therapy Group
- ☐ Parent/Family Therapy Group
- ☐ Family Outpatient Therapy
- ☐ Child/Adolescent Individual Outpatient Therapy

Primary Concerns:

- ☐ Anxiety
- ☐ Depression
- ☐ Coping/ Adjustment
- ☐ Trauma
- ☐ Irritability/ Low Mood
- ☐ Stress/Worry
- ☐ Self-injurious behavior
- ☐ Suicidal Ideation
- ☐ ADHD concerns
- ☐ Autism Spectrum concerns
- ☐ Aggression
- ☐ Non-Compliance
- ☐ Academic Problems
- ☐ Withdrawn Behavior
- ☐ Social Skill
- ☐ Parent Training
- ☐ Sleep
- ☐ Toileting
- ☐ Eating
- ☐ Chronic Illness/ Pain
- ☐ Adherence/Self-Management
- ☐ Health Behavior
- ☐ Developmental Disability

Additional Information Regarding Referral:

Insurance Information:

Primary Insurance:_____

Policy Number: _____

Group Number: _____

Policy Holder's Name: _____

Policy Holder's DOB: _____

Secondary Insurance:_____

Policy Number: _____

Group Number: _____

Policy Holder's Name: _____

Policy Holder's DOB: _____

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