LIGHTHOUSE
MENTAL WELLNESS

Referral Form

Thank you for your interest in Lighthouse Mental Wellness.
This form should be filled out by referring clinicians and faxed to **(781) 427-7071**.

Demographics

Name:

Date of Birth:

Address:

Phone Number:

Email Address:

For Minors:
Any special custody arrangements?
YES / NO

If yes, please specify:

Names of legal decision-makers:

Please note, parents are required to attend sessions

Insurance Information

Insurance Carrier:

Currently we take BCBS plans (except Medicare), OPTUM, and private-pay only

Treatment History

Current Therapist (and contact info):

Current Medications (Psych and Non-Psych):

Diagnoses (Psych and Med):

History of Substance Abuse: YES / NO

History of Suicide Attempts: YES / NO

Past Inpatient Admissions: YES / NO

Regularly attends therapy sessions YES/NO

Reason for Referral:

Availability: MORNING / AFTERNOON