BIRCH
PSYCHOLOGY

Birch Psychology Referral

Referring providers may complete & send to info@birchpsychology.com or faxed to 303.834.1026.

1. Patient/Client Information
Name: Date of Birth:
Guardian/Parent Name and Relationship (if a child):
Phone Number: Email:
Insurance ID (if applicable, e.g., Medicaid ID):

2. Reason for referral (therapy or assessment and other specifics):

3. Any special needs for the case: including language, court involvement, severity, urgency, collaboration, etc:

3. Referring to (applicable if referring to a specific clinician within the practice, rather than a general referral, or a particular services, e.g., child, individual, couple or family therapy):

4. Referring Providers Information (name, clinic, and contact information):

5. The client/patient gives permission for our practice to speak with the referring provider, please complete the following section for information to be released:

___ Notification of initial set up (to inform your provider you have been connected for services)
___ Progress ___ Medical History & Medication Information
___ Diagnosis ___ Other:

I give permission to share the above indicated protected health information with the referring provided indicated on this form.

_____ _____
Client/Patient Signature (if child, parent/guardian) Date