REFERRAL FORM

GENERAL

Campbell
PSYCHOLOGICAL SERVICES

Please instruct the family to contact us directly to request an appointment. This can be done by calling our Client Care Coordinator, Christine Artz, at (717) 422-6440 ext. 1 or filling out an on-line request form at https://hushforms.com/cps. By sending this form along with a release of information, we will be better able to serve the client as well as communicate with you about the referral.

Return via fax to (717) 620-0536 or mail to 25 East North Street, Carlisle, PA 17013
Please don't hesitate to call with any questions: (717) 422-6440

CLIENT

Child's Name: _____ DOB: _____ Gender: _____

Address: _____

Caregiver Name(s):_____

Caregiver(s) Relationship to Child: _____ Caregiver Phone:_____

Is English the primary language of the youth? ☐Yes ☐No

Is English the primary language of the caregiver(s)? ☐Yes ☐No

If No for either: What is the primary language? _____

Can the individual speak and understand English fluently? _____

Is a Release of Information attached to this referral? ☐Yes ☐No

In order to provide services, we are required to obtain consent from all individuals with legal custody of the child. Youth 14 and older may provide their own consent for services. For youth under 14 years:

- *If parents are divorced, it will be assumed that they have shared legal custody and, in accordance with Pennsylvania State Law, consent is needed from both parents. If documentation is provided of sole legal custody, only the consent of the custodial parent is needed.*
- *If someone other than the parent has legal custody, documentation is required (e.g., a copy of the custody order).*

REFERRAL SOURCE

Agency:_____

Contact Person: _____ Relationship to client:_____

Phone Number: _____ Email: _____

Best times to reach you: _____

REASON FOR REFERRAL

☐ *Psychological Evaluation:* What question or concern do you hope will be addressed by the evaluation? Is there a specific date by which the evaluation is needed? ☐No ☐Yes - date: _____
☐ *Therapy:* What issues or concerns are prompting this referral?

INSURANCE (if known)

☐Medical Assistance ☐Highmark Blue Shield ☐Capital Blue Cross
☐Other Blue Cross/Blue Shield ☐UPMC
☐Tricare (please note we are *not* in-network, so point- of-service fees may apply)
☐Other*: _____

If you select other, the client will need to self-pay and seek reimbursement from insurance for out-of-network coverage

Is this a CHIP Plan? ☐Yes ☐No ☐I don't know

Thank you!