THERAPY REFERRAL FORM

CHILDREN & YOUTH SERVICES

Campbell
PSYCHOLOGICAL SERVICES

PLEASE NOTE THAT COMPLETING THIS FORM DOES GUARANTEE AN APPOINTMENT. Availability for new clients is often limited and on a first come, first served basis.

Caseworkers may contact our Intake Coordinator to check on the status of a referral. If a signed release is included with the referral, we can provide an update.

CHECK ONE

☐ Family will contact Campbell Psychological Services to request services
☐ Please contact caseworker to discuss intake forms and scheduling
☐ Other: _____

CLIENT

Child's Name: _____ DOB: _____

Sex (for insurance billing): ☐ M ☐ F Gender Identity: _____

Grade: _____ School: _____ District: _____

Address: _____

Requested Office: ☐ Carlisle ☐ Chambersburg

Can the youth communicate fluently in English? ☐ Yes ☐ No

Can the caregiver communicate fluently in English? ☐ Yes ☐ No

If youth or caregiver cannot communicate fluently in English, primary language: _____

CHILDREN & YOUTH INFORMATION

Home County: _____

Contact Person / Caseworker: _____

Phone: _____ Email: _____

Best time(s) to reach you: _____

How long has CYS been involved with this youth/family? _____

Current status of CYS involvement: _____

CUSTODY / LIVING SITUATION

For children 13 and under, the individuals or entity with legal custody of the child must provide consent to treat. If two or more individuals share legal custody of the child, our office requires consent from all guardians. Youth 14+ can consent to their own treatment and control their treatment records.

Who has legal custody of this child? _____

Address: _____

Phone: _____ Relationship to child: _____

**If someone besides the biological/adoptive parent has custody, please provide a copy of the custody order.*

With whom does the child live? ☐ Same as above

Name:_____

Address: _____

Phone: _____ Relationship to child: _____

Who will be responsible for scheduling and keeping appointments for this child?

Name:_____

Phone: _____ Relationship to child: _____

REASON FOR REFERRAL

INSURANCE (check ALL that apply for this child)

☐ Medical Assistance ☐ Highmark Blue Shield ☐ Capital Blue Cross

☐ Other Blue Cross/Blue Shield ☐ Geisinger ☐ Quest

☐ UPMC ☐ Other*: _____

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

Return via fax to (717) 620-0536 or mail to 25 East North Street, Carlisle, PA 17013

THANK YOU!