MUSIC THERAPY REFERRAL FORM FOR INDIVIDUALS UNDER 21 YEARS OLD

TODAY'S DATE: _____ PARTICIPANT'S DATE OF BIRTH: _____

PARTICIPANT'S BIRTH NAME: _____ MA ID# (10-digit number): _____

PARTICIPANT'S PREFERRED NAME: _____ SS#: _____

PARTICIPANT'S HOME ADDRESS: _____

1. PARENT/LEGAL GUARDIAN'S NAME: _____
   PHONE: _____ EMAIL: _____
   MAILING ADDRESS: (if different from PARTICIPANT'S ADDRESS): _____
2. PARENT/LEGAL GUARDIAN'S NAME: _____
   PHONE: _____ EMAIL: _____
   MAILING ADDRESS: (if different from PARTICIPANT'S ADDRESS): _____

3. DOES THE PARTICIPANT HAVE MEDICAL ASSISTANCE BENEFITS? ***PLEASE CIRCLE ONE*** YES NO

4. DOES THE PARTICIPANT PLAN TO UTILIZE MEDICAL ASSISTANCE BENEFITS TO COVER THE COST OF MUSIC THERAPY OR DO THEY PLAN TO PRIVATELY PAY FOR SERVICES? ***PLEASE CIRCLE ONE***
   MEDICAL ASSISTANCE PRIVATE PAY UNSURE

5. PRIMARY INSURANCE OTHER THAN MEDICAL ASSISTANCE (INDICATE "NA" IF PARTICIPANT HAS NO OTHER HEALTH BENEFIT PLAN):
   PLAN NAME: _____ ID#: _____ GROUP: _____

6. PRIMARY CARE PHYSICIAN'S NAME: _____ PHONE: _____ FAX: _____
   ADDRESS: _____

PARTICIPANT DEMOGRAPHICS (Indicate NA if preferred not to answer):

RACE: _____ PRONOUNS: _____

ETHNICITY: _____ CHOSEN NAME (IF APPLICABLE): _____

SEXUAL ORIENTATION: _____ PRIMARY WRITTEN LANGUAGE: _____

GENDER IDENTITY: _____ PRIMARY SPOKEN LANGUAGE: _____

ASSIGNED SEX AT BIRTH: _____

REASON FOR SEEKING MUSIC THERAPY SERVICES

1. CURRENT MENTAL HEALTH DIAGNOSIS(ES):

_____

2. PLEASE DESCRIBE THE BEHAVIORAL HEALTH NEEDS INCLUDING SOCIAL AND EMOTIONAL HEALTH:

_____

3. PLEASE INDICATE PERSON'S PHYSICAL HEALTH NEEDS:

4. IS THE PERSON A DANGER TO THEMSELVES OR OTHERS? IF YES, PLEASE DESCRIBE:

5. CURRENT TREATMENT AND/OR THERAPIES (OTHER THAN MUSIC THERAPY)

SERVICE	AGENCY

ADDITIONAL INFORMATION

1. ***CIRCLE*** YOUR SCHEDULING AVAILABILITY. PARTICIPANT CAN ATTEND SESSIONS:
   DURING THE DAY NEEDS AN AFTER SCHOOL TIME
   LIST SCHEDULING PREFERENCES: _____
2. IF UTILIZING MEDICAL ASSISTANCE BENEFITS, WHICH OFFICE DO YOU PREFER TO BE SEEN? ***PLEASE CIRCLE ONE***
   HARRISBURG- 5920 JONESTOWN ROAD LEBANON- 426 N. 8TH ST. FIRST AVAILABLE
3. ACCESSIBILITY REQUIREMENTS: _____
4. COMMUNICATION NEEDS: _____
5. NAME OF THE PERSON COMPLETING THIS FORM: _____
   a. RELATIONSHIP TO INDIVIDUAL: _____
   b. IF DIFFERENT FROM PARENT/LEGAL GUARDIAN, PHONE: _____ EMAIL: _____

HOW DID YOU HEAR ABOUT WB MUSIC THERAPY? _____

PLEASE COMPLETE THIS FORM AND RETURN BY ONE OF THE FOLLOWING WAYS:

1) MAIL TO: WB MUSIC THERAPY, LLC 7728 GREEN HILL ROAD, HARRISBURG, PA 17112
*this address is an administrative address only and not a service location
2) FAX COMPLETED FORM TO: 717-566-6556

*If you are not the legal parent/ guardian of the referred individual, you must include a signed consent to release information.