MUSIC THERAPY REFERRAL FORM

NAME OF INDIVIDUAL FOR REFERRAL: _____
DATE OF BIRTH: _____
MA ID# (10-digit number): _____
DATE OF REFERRAL: _____

REFERRED INDIVIDUAL'S ADDRESS: _____
MOTHER'S NAME: _____
FATHER'S NAME: _____
LEGAL GUARDIAN'S NAME: _____
PREFERRED MAILING ADDRESS: (if different from above):_____

MOTHER'S PHONE: _____ EMAIL: _____
FATHER'S PHONE: _____ EMAIL: _____
REASON FOR REFERRAL: Include individual's diagnosis and any mental, physical, and/or emotional health needs:

_____
_____
_____

ADDITIONAL INFORMATION: Please include scheduling preferences and/or conflicts, best time to reach parent/guardian, accessibility concerns, and communication barriers:

_____
_____
_____

PERSON MAKING REFERRAL: _____
RELATIONSHIP TO INDIVIDUAL: _____
PHONE: _____ EMAIL: _____

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

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
OR
FAX FORM TO 717-737-7486

IF FORM WAS SENT TO YOU VIA A LINK, SAVE THE FILE ON THE HIPAA COMPLIANT DRIVE SITE WHERE YOU ACCESSED THE FORM
*If you are not the parent or guardian of the referred individual, you must include a signed consent to release information.