MUSIC THERAPY REFERRAL FORM FOR ADULTS

NAME OF INDIVIDUAL FOR REFERRAL:

DATE OF BIRTH:

DATE OF REFERRAL:

ADDRESS OF RESIDENCE:

PHONE: EMAIL:

REASON FOR REFERRAL (PLEASE CHECK ALL THAT APPLY AND BRIEFLY DESCRIBE)

COMMUNICATION

SOCIAL

BEHAVIORAL

EMOTIONAL

MOTOR

OTHER

PRIMARY PHYSICAL HEALTH DIAGNOSIS(ES):

PRIMARY MENTAL HEALTH DIAGNOSIS(ES):

ACCESSIBILITY INFORMATION (INDICATE INFORMATION SUCH AS KNOWN SCHEDULING PREFERENCES, TRANSPORTATION REQUIREMENTS, LOCATION OF SERVICE NEEDS, LANGUAGE DIFFERENCES, PREFERRED METHOD OF CONTACT)

ARE YOU ENROLLED WITH A PA MEDICAL ASSISTANCE WAIVER PROGRAM? IF YES, PLEASE IDENTIFY NAME OF PROGRAM AND CONTACT PERSON.

NAME AND RELATIONSHIP OF PERSON COMPLETING THIS FORM:

CONTACT INFORMATION FOR PERSON COMPLETING THIS FORM: PHONE- EMAIL-

PLEASE COMPLETE AND RETURN THIS FORM TO:

WB MUSIC THERAPY, 7728 GREEN HILL ROAD, HARRISBURG, PA 17112
*this address is an administrative address only and not a service location

OR

FAX THIS FORM TO 717-737-7486