MUSIC THERAPY REFERRAL FORM

NAME OF INDIVIDUAL FOR REFERRAL: _____
DOB: _____
MA ID# (10 digit number): _____
ADDRESS: _____
MOTHER'S NAME: _____
FATHER'S NAME: _____
LEGAL GUARDIAN'S NAME: _____

MOTHER HOME PHONE: _____CELL: _____ EMAIL: _____
FATHER HOME PHONE: _____CELL: _____ EMAIL: _____
REASON FOR REFERRAL: Please state the referred individual's mental, physical, and 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 THE ADDRESS BELOW
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.

WB MUSIC THERAPY, LLC 7728 GREEN HILL ROAD, HARRISBURG, PA 17112