Wolf Pack
Consulting and Therapeutic Services, LLC
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Referral for Services

Identified Client Information: Date Referred:

Preferred Name:
Legal Name:
Race/Ethnicity:
Email:
Primary Language:
Phone Number:
Address:
School and grade (if referral is for a child):
Insurance Provider / CCO:
Insurance ID:

Date of Birth:
Pronouns:
Gender designation for health insurance:
Identified Gender:
Interpreter Needed: ☐ Yes ☐ No
Can we leave a message: ☐ Yes ☐ No
Group Number:
Insurance Phone Number:

Parent/Guardian/Care Provider Information (If referral is for a child):

Preferred Name:
Legal Name:
Race/Ethnicity:
Email:
Primary Language:
Phone Number:
Will they be involved in service? ☐ Yes ☐ No (if no, skip to next section)
Address:
Insurance Provider / CCO:
Insurance ID:

Relationship: Date of Birth:
Pronouns:
Gender designation for health insurance:
Identified Gender:
Interpreter Needed: ☐ Yes ☐ No
Can we leave a message: ☐ Yes ☐ No
Group Number:
Insurance Phone Number:

Other Parent/Guardian/Care Provider Information (If referral is for a child):

Preferred Name:
Legal Name:
Race/Ethnicity:

Relationship: Date of Birth:
Pronouns:
Gender designation for health insurance:

Email: Identified Gender:

Primary Language: Interpreter Needed: ☐ Yes ☐ No

Phone Number: Can we leave a message: ☐ Yes ☐ No

Will they be involved in service? ☐ Yes ☐ No (if no, skip to next section)

Address:

Insurance Provider / CCO: Group Number:

Insurance ID: Insurance Phone Number:

Other Individuals Involved in the Service(s):

Preferred Name: Relationship: Date of Birth:

Legal Name: Pronouns:

Race/Ethnicity: Gender designation for health insurance:

Email: Identified Gender:

Primary Language: Interpreter Needed: ☐ Yes ☐ No

Phone Number: Can we leave a message: ☐ Yes ☐ No

Address:

Insurance Provider / CCO: Group Number:

Insurance ID: Insurance Phone Number:

Preferred Name: Relationship: Date of Birth:

Legal Name: Pronouns:

Race/Ethnicity: Gender designation for health insurance:

Email: Identified Gender:

Primary Language: Interpreter Needed: ☐ Yes ☐ No

Phone Number: Can we leave a message: ☐ Yes ☐ No

Address:

Insurance Provider / CCO: Group Number:

Insurance ID: Insurance Phone Number:

Legal Guardian (of any children, if different from above):

Relationship: Pronouns: Branch (if DHS):

Phone: Email:

Reason for Referral: (In your words, please describe concerns or behaviors that initiated this referral)

Mental Health Services Requested:

Type	For who (List all from above for each service requesting)
☐ Assessment ONLY	
☐ Individual Therapy	
☐ Family Therapy	
☐ Group Therapy	
Please specify group if known:	
☐ Skill Building	
☐ Peer Support	
☐ Medication Evaluation / Management	

Substance Use Disorder Services Requested:

Type	For who (List all from above for each service requesting)
☐ Assessment ONLY	
☐ Individual Therapy	
☐ Family Therapy	
☐ Group Therapy	
Please specify group if known:	
☐ Skill Building	
☐ Peer Support	
☐ Medication Evaluation / Management	
☐ Acupuncture	

Service Location Requested:

- ☐ Wolf Pack Office
- ☐ School:
- ☐ Home / Community Location:
- ☐ DHS Branch:

Other Agency or System Involvement (i.e. child welfare, education IEP/504, justice system):

Referent Information:

Name:

Phone:

Email:

Where did you hear about Wolf Pack?

Staff only:

Received Date:

Assessment Date:

Assigned:

Assigned:

Assigned:

Notes:

☐ Insurance Verified

☐ Census

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