ASPIRE
Wellness Center

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Phone: (443) 442-1568
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www.aspire-wellness.com

Therapy Services Referral Form

(Please Print or Type in Black Ink)

Client Name: Insurance (MCO/ID Number):

(If minor, Guardian Name): Primary Phone:

DOB: Age: Gender: Race: Sex: Marital Status: Single

Address: City: State:

Emergency Contact: Relationship:

Address: 1600 Pennsylvania Avenue Phone:

Referral Source:

Referring Agency: Contact Name:

Address: Phone Number:

Therapy Requested (check all that apply):

LOCATION: ☐Therapy at Aspire ☐Therapy in Community (state where)

MODALITY: ☐Individual Therapy ☐ Family Therapy ☐Group Therapy

Reason for Referral (check all that apply):

☐Behavior/Conduct Challenges	☐Parenting Challenges	☐Educational Challenges	☐Employment Problems
☐Financial Instability	☐Legal Issues	☐Recently Incarcerated	☐Physical/Emotional Abuse
☐Relationship Issues	☐Sexual Abuse	☐Social Challenges	☐Substance Use
☐Homeless	☐Suicidal	☐Homicidal	☐Family Problems

Current Symptoms/Behaviors/Issues (check all that apply):

☐Anxiety/Panic	☐Attachment Issues	☐Depressed	☐Pyromania
☐Homicidal Ideation	☐Suicidal Ideation	☐Hopeless/Helpless	☐Hyperactive
☐Impulsive	☐Irritable	☐Sleep Disturbances	☐Isolative
☐Lying/Manipulative	☐Manic	☐Mood Swings	☐Obsessive/Compulsive
☐Property Destruction	☐Self-Care Issues	☐Educational Challenges	☐Employment Problems
☐Parole/Probation	☐Elopement	☐Recently Incarcerated	☐Physical/Emotional Abuse
☐Sexually Inappropriate	☐Sexual Abuse	☐Social Challenges	☐Substance Use
☐Truancy	☐Anti-Social	☐Withdrawn	☐Family Problems
☐Oppositional	☐Verbal Aggression	☐Oppositional	☐Self-Injurious
☐Physical Aggression	☐Stealing	☐Past/Present Trauma	☐Separation Anxiety

Current Diagnosis (list if known): ☐**Unknown**

Diagnosis	DSM V/ICD Code

Signature: _____ Date: _____

Please fax completed form to **Attention Amanda Schillinger** at (443-442-1569)