MIDWEST ENCOURAGEMENT & COUNSELING CENTER

220 W 15th St. Kearney, NE 68845
Phone: 308-236-0500 Fax: 308-237-5225

REFERRAL FORM

Date: ___________________

Name: ____DOB: _________________________
Gender: ____
Parent/Guardian:______________________________________Phone:_________________________
Address:____
Email: ____
Referred by: ____

State ward: N/Y   If Yes:
Caseworker: ____Phone:____________________
Biological Parent(s): ____
Foster Parent(s):____

Name of Insurance: ____
Name of Policy Holder: ________________________________DOB of Insured:_________________
Employer: ____
Group# _________________________________Policy # ___________________________________

Diagnosis if known:____

PRESENTING ISSUES:____
____
____
____
____
____
Pertinent Medical Information: ____

____Client currently has a Psychiatrist/APRN   Psychiatrist Name_________________________
____Client needs appointment scheduled with a Psychiatrist ASAP

NOTES FOR ADMINISTRATIVE USE ONLY   ___Wait list: ________________
Requested or preferred clinician:

Date and Time of Intake _______________________________ **with**__________________________

Rev. 5/2023