Referral to Grossman & Grossman for Specialty Counseling Services

Services provided throughout Arizona

Today's Date:_____

Client Name _____ Date of Birth _____ Age _____ Gender _____

Client lives with Name:_____Relationship:_____

Address _____

City _____ State _____ Zip _____ Phone _____

Payment Source: ___Self Pay ____AHCCCS: ____ Other: _____

Insurance/Policy Number:_____

Home Health Agency:_____

Case Manager Name:_____

Office Phone: _____ext_____Cell Phone_____

Email: _____Fax:_____

Parent Name _____ Phone_____

Is there a legal Guardian/DCS involved? ____Yes ___No If yes, provide name/contact information:

_____ Relationship_____ Phone _____

Parent/Guardian is aware of referral: No ____ Yes ____

Any Family Members currently receiving services? _____ If so, which therapist? _____

Is client part of a sibling set being referred at the same time? _____

Cultural and language considerations: No ____ Yes ____ specify language/need _____

Primary Care Physician (Name, Address, phone and Fax Number):

_____

Primary Diagnosis _____

Describe the issues the team would like assistance with:

_____

_____

_____

Counseling services requested: ___Individual ___Family

Location of services preferred: ____ Telehealth Very limited in office may be possible

Referring Individual's Signature _____ Date _____

Please Fax/Email this referral form with a copy of any applicable documentation to:

480-609-9552/team@grossmantherapy.com

Grossman & Grossman, Ltd. PO Box 14948, Scottsdale

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