LEWC Inc. Adult Referral

Please DO NOT Email (FAX ONLY) (410) 443-0842

Date of Referral:	**Client's Name:**
Primary Caregiver Name (If different from Client):	**Date of Birth:**
Gender:	**Employment Status:**
Race/Ethnicity:	**Last 4 Digits of SSN:**
Street Address:	**Referrer's Name and Organization:**
City/State/Zip:	**Referrer's Phone #:**
Client's Phone #:	**Referrer's Address/City/State/Zip:**

Consent For Referral: (Circle Answers)
As the referring party, I have received written consent to release information from the primary caregiver and/or client to make this referral to Life's Energy Wellness Center Inc. **YES** **NO**

Additionally, as the referring party, I have included a copy of the signed form by the caregiver and/or client to release information to Life's Energy Wellness Center Inc. **YES** **NO**

Insurance Guarantor Information (to whom statements are Sent) **Name:**	
Address:	
City: **State:**	**Zip:**
Insurance Guarantor Phone #:	
Type of Insurance:	**Member/Group Number:**

Has client experienced Any of the following: (Circle Answers)	**Clients reason for seeking Treatment**:
Physical Abuse: YES NO Bullying: YES NO Sexual Abuse: YES NO Domestic Violence: YES NO Emotional Abuse: YES NO Incarceration: YES NO Neglect: YES NO Victim of Crime: YES NO DWI/DUI: YES NO Pregnant: YES NO SI/HI: YES NO	__________ __________ __________ Additional Comments: __________ __________ __________ __________ __________