Strategic Therapy Associates Referral Form

Date of Referral:_____

Region: ☐ Danville ☐ Farmville ☐ Galax ☐ Lynchburg ☐ Martinsville ☐ Norfolk ☐ Richmond ☐ Roanoke

Name of Client: _____ DOB: _____ SSN: _____ Age: _____ Gender: _____ Race:_____

Parent/Guardian name: _____ Relationship: _____ Parent/Guardian aware we will be contacting them: _____

Who has legal guardianship of this minor? _____ Is there a court order or custody agreement?____ If yes, please fax to 434-237-9454

Address: _____ City: _____ State: _____ Zip: _____

Cell phone: _____ Home phone: _____ Other phone: _____ Email: _____

Referring Person: _____ Agency: _____ Phone: _____ Fax: _____

Email: _____Address: _____ City: _____ State: _____ Zip: _____

Service(s) Requesting

- ☐ Casey Life Skills
- ☐ Evidence-Based Brief Strategic Family Therapy (BSFT)
- ☐ Evidence-Based Functional Family Therapy (FFT)
- ☐ Evidence-Based Trauma-Focused Cognitive Behavior Therapy- CBT
- ☐ Home-Based Counseling
- ☐ Intensive In-Home Counseling
- ☐ Intensive Care Coordination
- ☐ Mental Health Skill Building
- ☐ Outpatient Therapy (Individual)
- ☐ Outpatient therapy (Family)
- ☐ Parent Aide Support
- ☐ Parent Reunification
- ☐ Substance Abuse Counseling
- ☐ Substance Abuse Evaluation
- ☐ Substance Abuse Relapse Prevention
- ☐ Therapeutic Mentoring
- ☐ Other

Reason for Referral (name specific behaviors):

Please include a copy of the client's insurance card and/or purchase order/ IFSP

Medicaid/Commercial Insurance Provider: _____

Policy #: _____ MCO/Group: _____ MCO#/Group ID #: _____

Subscriber Information for Commercial/Private Insurance:

Subscriber Name: _____ DOB: _____SSN: _____ Relationship to client: _____

Secondary Medicaid/Commercial Insurance Provider: _____

Policy #: _____ MCO/Group: _____ MCO#/Group ID #: _____

Subscriber Information for Commercial/Private Insurance:

Subscriber Name: _____ DOB: _____SSN: _____ Relationship to client: _____

CSA/Vendor Contract Provider/Source: _____Contact name & phone #:

Purchase Order #: _____ Contract approval dates: _____ # of units approved:_____Week ☐ Month ☐

Fax Referral Form to: 434-237-9454
Phone: 1-800-716-3534

Call or visit our website for more information
www.StrategicTherapyAssociates.com