



CLIENT Referral

Date: _____

Name: _____ Age: _____ D.O.B.: _____

Ethnicity: _____

If referral is for a minor,

Parent's (or Legal Guardian's) Name: _____

___ Yes ___ No English is spoken. If no, language spoken is _____. Interpreter scheduled for assessments: Name _____ Tel _____.

Home Address: _____

City: _____ State: _____ Zip: _____

(H) Phone: _____ (W) Phone: _____ (Cell) Phone: _____

Email: _____

Diagnosis or illness: _____

Symptom / need for therapy: _____

Type of therapy being requested: ___ Music Therapy ___ Music 4 Life

IEP (Individualized Education Program) ___ yes ___ no ___ pending

Current Physician / Therapist / Credentials: _____

Specialty: _____ Phone: _____

What therapies have been received in the past?

Therapies: _____

Provider: _____

Response to therapy: _____

Referred by:

Name/Title/Agency: _____

Email: _____ Phone: _____

CCTA Therapist assigned: _____ by: _____

Payment source: ___ Private Pay ___ Acumen ___ Sliding Fee ___ Grant ___ Medicaid ___ Medicare
___ Private Insurance: _____ (attach copy of insurance card)

Fee approved: \$ _____ by: _____

Part I Assessment (Intake) scheduled: _____

Part II Assessment (Client) scheduled: _____