LIFE MANAGEMENT ASSOCIATES, LLC

FAX REFERRAL FORM

REFERRAL TO: ☐ **Jeffrey A. Watson, M.Ed., LCPC, LMFT, NCC, FAPA**
☐ **Mary L. Watson, MS, LCPC, LMFT**

INSTRUCTIONS

Please complete as much information as you have available. Basic contact information is acceptable. Please fax this form to (406) 782-1318 or mail this form to 2510 Continental Drive, Butte, MT 59701. We will contact the parties listed to schedule an appointment. If this is an urgent referral, please call (406) 782-4778 to schedule an appointment and indicate its urgency. Please follow-up the phone call by sending this completed form to our office either by fax or mail. We can usually accommodate urgent referrals the same day or within 48 hours.
Thank you for choosing Life Management Associates, LLC!

SOURCE OF REFERRAL

Date _______/_______/_______

Name ____

Company/Organization ____

Address ____ City ____________________ State _________ Zip ______________

Phone No. (Office) (_____) __________________ (Fax) (_____) __________________ (Other) (_____) ___________________

E-Mail Address: ____

Relationship: Medical Provider ☐ Case Manager ☐ Therapist ☐ Attorney ☐ Other Professional ☐ *specify:* ______________________

SERVICES REQUESTED

LOCATION REQUESTED

☐ Mental health evaluation

Specify: Child ☐ Adolescent ☐ Adult ☐

Rule-Out (if applicable): _________________________________

☐ Psychotherapy

Specify: Individual ☐ Couples ☐ Family ☐ Group ☐

☐ Family systems evaluation and interpretation of results

☐ Child custody evaluation and interpretation of results

☐ Clinical supervision and consultation with professional

☐ Evaluation of treatment records, in consultation with professional

☐ Guardian ad litem services for a minor child

☐ Other services ____

CLIENT INFORMATION

Client Name (First) ________________________ (MI) ____ (Last) ________________________________ Marital Status ____________

Address ____ City ___________________ State _________ Zip ______________

Phone No. (Home) (_____) _________________ (Work) (_____) __________________ (Cell) (_____) ___________________

Sex: F ☐ M ☐ Age __________ Date of Birth _______/_______/_______

Payment Source: Insurance ☐ EAP ☐ Self-Pay ☐ Insurance Name ____

LIFE MANAGEMENT ASSOCIATES, LLC

FAX REFERRAL FORM

Reason for Referral ____

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PARENT/LEGAL GUARDIAN INFORMATION OR PARTNER INFORMATION

if client is a minor or client is referred for couples therapy

Name (First) ________________________ (MI) ____ (Last) _________________________________ Marital Status _________________

Address ____ City ____________________ State _________ Zip ______________

Phone No. (Home) (_____) __________________ (Work) (_____) _________________ (Cell) (_____) __________________

Sex: F ☐ M ☐ Age __________ Date of Birth _______/_______/_______

Relationship: Spouse ☐ Parent/Legal Guardian ☐ Other ☐ *specify:* ____

Other Pertinent Information ____

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OFFICE USE ONLY

Contact with Referral: _____/_____/_____ Date — Contact Made / Voicemail Msg / No Answer

_____/_____/_____ Date — Contact Made / Voicemail Msg / No Answer

_____/_____/_____ Date — Contact Made / Voicemail Msg / No Answer

Appointment Scheduled: No ☐ Yes ☐ *If yes,* _____/_____/_____ Date at ____:______ Time AM / PM Packet Mailed? ☐

2510 Continental Drive • Butte, MT 59701 • Phone: 406-782-4778 • Fax: 406-782-1318