



# W.F. PRECOURT COUNSELING SERVICES

## William F. Precourt LPCMH CADC

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Ste A  
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(F) 302.736.1280  
PrecourtCounseling.com

## Professional Referral Form

### Referring Office Information

Referring Office / Business \_\_\_\_\_

Business Phone Number (\_\_\_\_) \_\_\_\_-\_\_\_\_

Diagnosis / Reason for Referral  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

### Preferred day / time for appointment

Day  M  T  W  R  F

Time \_\_\_\_:\_\_\_\_ AM / PM

### Type of Service Needed

- Individual Counseling
- Family Counseling
- Substance Abuse Counseling
- Substance Abuse Evaluation
- Christian Counseling

### Client Contact Information

First & Last Name \_\_\_\_\_ MI \_\_\_\_\_

Gender M / F

SSN \_\_\_\_-\_\_\_\_-\_\_\_\_

Date of Birth \_\_\_\_/\_\_\_\_/\_\_\_\_

Address Line 1 \_\_\_\_\_

Address Line 2 \_\_\_\_\_

City \_\_\_\_\_ State \_\_\_\_\_ Zip Code \_\_\_\_\_

Home phone (\_\_\_\_) \_\_\_\_ - \_\_\_\_\_

Cell phone (\_\_\_\_) \_\_\_\_ - \_\_\_\_\_

If minor, parent / guardian name \_\_\_\_\_

*Insurance Information*

Primary Insurance Company \_\_\_\_\_

Member ID \_\_\_\_\_ Group# \_\_\_\_\_

Policy Holder Name \_\_\_\_\_

Policy Holder Date of Birth \_\_\_\_/\_\_\_\_/\_\_\_\_

Secondary Insurance Company \_\_\_\_\_

Member ID \_\_\_\_\_ Group# \_\_\_\_\_

Policy Holder Name \_\_\_\_\_

Policy Holder Date of Birth \_\_\_\_/\_\_\_\_/\_\_\_\_

*Office Use Only*

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Date Received \_\_\_\_/\_\_\_\_/\_\_\_\_

Appointment Date \_\_\_\_/\_\_\_\_/\_\_\_\_

Appointment Time \_\_\_\_:\_\_\_\_ AM / PM

Unable to complete referral due to  
\_\_\_\_\_  
\_\_\_\_\_

Date confirmation fax or phone call to referral source \_\_\_\_/\_\_\_\_/\_\_\_\_