Northland Counseling Services

Referral for Patient Treatment

This is not a patient record request. Please Print

Dr. Michael Murray-Medical Director for Northland Counseling Services
Physician's Name

Referral for treatment requested for:
☐ Chemical Dependency
Per HSS 61.59 (3)(c)
☐ Mental Health
Per HSS 61.79 (5)

Northland Counseling Services PO Box 1062 Hayward WI 54843
Clinic Name & Address

Client's Name Date of Birth

Presenting Problem

Preliminary Diagnosis

I have seen this client for an initial diagnostic examination. The above reflects my initial assessment as to his/her diagnosis. In my professional judgment there is a need for ongoing psychotherapy/counseling. I am contacting you on behalf of my client to request that you prescribe the treatment. I anticipate the length of time of counseling to be _____.

Please sign below and return to **Northland Counseling Services** if you concur with this. It would also be helpful to know of any medications you have prescribed for this patient. Thank you for your assistance in this matter.

Therapist's Name Date

PO Box 1062 Hayward, WI 54843 (715) 634-0222
Office Address Phone

Prescribed Medications

Any other concerns

I hereby concur with above diagnosis and prescribe counseling for _____.

Ph.D./MD's Signature MA Provider Number or UPIN

☐ I would like to receive a report.

Consent for Disclosure of Confidential Information

I hereby grant permission for the disclosure of case file information between my medical doctor and my therapist for the purpose of obtaining medical referral treatment.

Client's Signature Date Witness Date

Parent/Legal Guardian's Signature Date