Uplift Counseling Services
222 Chalan Santo Papa · Reflection Center Suite 102 Hagatña, Guam 96910
www.westcare.com · https://uplift.westcare.com/
671- 472-0218 ext. 103

OUTPATIENT REFERRAL FORM

Client Information			
Last Name:	**First Name:**		**M.I.**
Social Security Number:	**Date of Birth:**	**Age:**	**Marital Status:**
Sex: □ Male □ Female	**Gender Identity:**		**Sexual Orientation:**
Ethnicity:	**Interpreter Services Needed:** □ **Yes** □ **No**		**If yes, in what language:**
Residential Address:	**City:**	**State:**	**Zip Code:**
Mailing Address: (If different from residential)	**City:**	**State:**	**Zip Code:**
Home Phone:	**Permission to leave a message?** □ Yes □ No	**Other Phone:**	**Permission to leave a message?** □ Yes □ No
Employment Status: □ Employed □ Unemployed □ Retired □Student		**Employer/ School:**	
Work Phone:	**Permission to leave a message?** □ Yes □ No	**Email Address:**	

Insurance: □ Self-Pay □ Medicaid □ Medicare □ Aetna □ SelectCare □ NetCare □ TakeCare □ StayWell
□ Other: _____

Emergency Contacts:		
Name:	**Contact:**	**Relationship:**
Name:	**Contact:**	**Relationship:**

Reason For Referral:

_____

_____

_____

Referral Source Information:

Referring Source: □ Self-Referral □ Other (Please Specify): _____

Name of Referring Person:	**Contact Information:**

Services Referred For:
□ Substance Use Assessment □ Substance Use Individual Counseling □ Substance Use Group Counseling
□ Behavioral Health Individual Counseling □ Behavioral Health Group Counseling □ Other: _____

Release of Information

I,_____ authorize WestCare Pacific Island, Inc. to share this form with _____. An additional release of information will be required to discuss treatment.

Client's Signature: _____ Date: _____
□ Please check box if patient provided verbal consent.

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Date & Time Received:	Received by:

12/18/20 lc