

# Referral/Face Sheet

David's Loft Clinical Programs  
21 West Road, Ste 111, Towson, MD 21204  
Office (410) 494-9440 Fax (410) 494-9441

Submit referrals via Fax to (410) 494-9441 or email  
referrals@davidsloft.com

Date: \_\_\_\_\_

Name: \_\_\_\_\_ DOB: \_\_\_\_\_ SS #: \_\_\_\_\_  
Address: \_\_\_\_\_  
Street City State Zip Code  
Telephone: \_\_\_\_\_  
Home Work Marital Status Race Sex

## Insurance Information:

\_\_\_\_\_  
Name of Insurance Company Address Phone #  
\_\_\_\_\_  
Subscriber's Name Subscriber's SS # Subscriber's DOB  
\_\_\_\_\_  
Medicaid # Group # Client's Relationship to Subscriber  
I authorize the release of any medical or other information necessary to process this claim. I also request payment of government benefits to David's Loft Clinical Services. I authorize payment of medical benefits to David's Lost Clinical Services. I also understand that payment of is my responsibility and David's Loft Clinical Services has the right to use any means necessary to collect fees to include submission of my name and other information to a collection agency for the purposes of fee collection.  
\_\_\_\_\_  
Signature (patient or parent or guardian if minor) Date

## Office Use Only

Axis I: \_\_\_\_\_  
Axis II: \_\_\_\_\_  
Axis III: \_\_\_\_\_  
Axis IV: \_\_\_\_\_  
Axis V: \_\_\_\_\_

State Reason for Referral

Health Problems: \_\_\_\_\_  
Who referred you to our agency? \_\_\_\_\_

\_\_\_\_\_  
Primary Caretaker Relationship to Client Phone  
Street City State Zip Code

\_\_\_\_\_  
Primary Health Care Provider Phone  
Street City State Zip Code

Please list two people who we can contact in the case of an emergency, if the primary caretaker is unavailable:

\_\_\_\_\_  
Name Phone  
Street City State Zip Code  
\_\_\_\_\_  
Name Phone  
Street City State Zip Code