resilient roots

Referral Form for Mental Health Services

Client Information:

Name:	Date of Birth:	Race/Ethnicity:
Gender: ☐ Male ☐ Female	School & Grade:	

Parent or Legal Guardian Information:

Name of Parent or Legal Guardian:	Relation to Child:
Contact Numbers:	Address:

Payment Information:

Type of Insurance:	
Insurance ID#:	Phone #:

Referral Source Information: Complete this section so we can contact you after the referral is made.

Name:	Mailing Address:
Phone#:	Email address:
How did you hear about Resilient Roots, LLC?	

PCP Information:

Prescribing Physician Name & Phone:

Reason for referral for treatment: In your own words, describe the child's need for mental health services.

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Additional Comments: _____

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Please email form to brittany.jaspers@resilientrootsllc.com