IEAP
Institute for Equine Assisted Practices

Referral Form

Please fax form to: 207-657-1210

Client Name: **Date of Birth:** **Gender: M /F**

Class Member: Y / N

Address:

Home Phone: **Cell Phone:** **Permission to leave a message: Y / N**

Guardian Name: **Home Phone:** **Cell Phone:**

Brief description of issues/concerns:

Mental Health: ___
Substance Abuse: ___
Co-Occurring: ___

Safety concerns (Domestic Violence, Anger/Aggression): Y / N
If Yes, please specify:

Legal Issues: Y / N
If yes, please specify:

Is the client in crisis? Y / N

Was crisis information given? Y / N

Counseling Preferences

Times **better** for Client
Mornings / Afternoons

Days that **do not** work for client
M T W Th

**** Insurance Information – *Please be sure to complete all information* ****

Primary Insurance:_____
Identification number:_____Group Number: _____
Phone #:_____Prior Auth required? Y / N

Secondary Insurance:_____
Identification number:_____Group Number: _____
Phone #:_____Prior Auth required? Y / N