WBMT
WB Music Therapy, LLC
7728 Green Hill Road Harrisburg, PA 17112
(717) 468-1684 or (717) 514-8160

CHILD/ADOLESCENT MUSIC THERAPY REFERRAL FORM

DATE OF REFERRAL: _____ DATE OF BIRTH: _____

REFERRAL'S BIRTH NAME: _____ MA ID# (10-digit number): _____

REFERRAL'S PREFERRED NAME: _____ SS#: _____

PRIMARY INSURANCE NAME, ID# AND GROUP#: _____

PRIMARY CARE PHYSICIAN'S NAME, ADDRESS, PHONE, AND FAX: _____

_____

REFERRAL'S ADDRESS: _____

PARENT/GUARDIAN'S NAME: _____

PARENT/GUARDIAN'S NAME: _____

LEGAL GUARDIAN'S NAME (if other than parent/guardian(s) listed above): _____

PREFERRED MAILING ADDRESS: (if different from above): _____

PARENT/GUARDIAN'S PHONE: _____ EMAIL: _____

PARENT/GUARDIAN'S PHONE: _____ EMAIL: _____

REASON FOR REFERRAL (include individual's diagnosis(es) and any mental, physical, and/or emotional health needs and what you hope for the individual to gain from music therapy services):

_____

_____

_____

DOES REFERRAL RECEIVE OTHER THERAPY SERVICES? IF YES, PLEASE LIST THE TYPE(S) OF THERAPY AND PROVIDERS: _____

_____

ADDITIONAL INFORMATION (please include scheduling preferences and/or conflicts, best time to reach parent/guardian(s), accessibility concerns, communication barriers and if referral poses a risk of harm to themselves or others): _____

_____

_____

PERSON MAKING REFERRAL: _____

RELATIONSHIP TO INDIVIDUAL: _____

PHONE: _____ EMAIL: _____

PLEASE COMPLETE THIS FORM AND RETURN ONE OF THE FOLLOWING WAYS:

1) MAIL TO: WB MUSIC THERAPY, LLC 7728 GREEN HILL ROAD, HARRISBURG, PA 17112
*this address is an administrative address only and not a service location

OR

2) FAX COMPLETED FORM TO: 717-737-7486

IF FORM WAS SENT TO YOU VIA A LINK, SAVE THE FILE ON THE HIPAA COMPLIANT DRIVE SITE WHERE YOU ACCESSED THE FORM

*If you are not the parent or guardian of the referred individual, you must include a signed consent to release information.