HWS
BEST HEALTH, LLC

Outpatient Referral Form

Required fields marked in RED

Today's Date: _____ **Client's Full Name:** _____

Preferred Name: _____ **Sex Assigned at Birth:** ☐ Male ☐ Female

Gender Identity: ☐ Cis Male ☐ Cis Female ☐ Trans Woman ☐ Trans Man ☐ Non-binary ☐ Decline to Specify

Sexual Orientation: ☐ Straight ☐ Asexual ☐ Bisexual ☐ Lesbian/Gay ☐ Decline to Specify

Client's Address: _____ **City/State/Zip:** _____

Client's Date of Birth: _____ **Client's SSN:** _____-_____-_____

Phone Number: _____

Email Address: _____

Client's Insurance Company: _____

Insurance Policy #: _____ **Insurance Group #:** _____

Reason for Referral:

Person Completing Referral: _____ **Title:** _____

Contract Email Address: _____ **Phone #:** _____

If client is a minor, please complete the information below

School Name: _____ **Grade:** _____

Parent/Guardian's Name: _____

Parent/Guardian's Contact Number: _____

Parent/Guardian's Email Address: _____

Send completed referrals to referrals@hwsbesthealth.com or contact us at: (330) 442-2664

SUBMIT