THE Guidance CENTER

www.tgcaz.org

2187 N. Vickey Street
Flagstaff, AZ 86004

Tel.: (928) 527-1899
Email: scheduling@tgcaz.org

MEMBER REFERRAL FORM

Today's Date: ____________________

MEMBER DEMOGRAPHIC INFORMATION:

Name: ______________________________________ Date of Birth: ______________ S.S#: ____________
First *Middle* *Last*

Address: ______________________________________ Work: ☐Full Time ☐Part Time ☐Disability ☐Unemployed ☐N/A

______________________________________ Age: _____ School: _______________ Grade: _____

Telephone:(____)______________ Leave Messages: ☐Yes ☐NO (____)______________ Leave Messages: ☐Yes ☐NO
Home Cell

Marital Status: ☐ Married ☐Single ☐Divorced ☐Separated ☐Widowed ☐Significant Other: ______________

Name of Spouse/Other:(if applicable): ______________________ Telephone:(____)______________ Leave Message?: ☐Y ☐N

If Minor:

Where does the child currently reside?: ☐ Both Parents ☐Mom ☐Dad ☐Other: ______________________

Parent/Guardian's Name ______________________________ Relationship: ______________

Current Address: ______________________________ Telephone No: ______________

Parent/Guardian's Name ______________________________ Relationship: ______________

Current Address: ______________________________ Telephone No: ______________

INSURANCE INFORMATION:

1. Type of Insurance: ☐No Insurance/Private Pay ☐ Medical ☐Medicare ☐Medicaid/AHCCCS ☐EAP ☐Other

Insurance Name: ____________________ Policy/Member ID: ______________ Group #: __________

Primary Card Holder's Name: ________________________ Date of Birth: ____________ S.S.#: __________

Relationship to Primary Card Holder: ☐Self ☐Spouse ☐Child ☐Other

2. Type of Insurance: ☐No Insurance/Private Pay ☐ Medical ☐ Medicare ☐Medicaid/AHCCCS ☐EAP ☐Other

Insurance Name: ____________________ Policy/Member ID: ______________ Group #: __________

Primary Card Holder's Name: ________________________ Date of Birth: ____________ S.S.#: __________

Relationship to Primary Card Holder: ☐Self ☐Spouse ☐Child ☐Other

REFERRAL SOURCE:

Referred By: ____________________________ Title: ______________ Telephone: ____________

Facility/Office Name: ____________________ Address: ______________________________

Email: ______________________________________ Fax: ______________________

REASON FOR REFERRAL:

Service(s) Requesting: ☐Individual ☐Family/Couple ☐Group ☐Evaluation(Specify): ______________________

If Evaluation, need by? ______________ ☐Other ______________________________

Brief summary of your concerns:

____

____

____

If Evaluation, date needed by? ______________ Court Ordered? ☐ Y ☐ N Court Date? __________ By Whom? __________

Previous behavioral/mental health treatment? ☐Yes ☐No? Where: ______________________________

For What? ______________________________ By Whom?: ______________________________

What was the diagnosis/outcome? ____

Current Medications:

____

____

Email completed form to: Scheduling@tgcaz.org