

MOMENTUM SERVICES, LLC

50 Parkwood Drive Chambersburg, PA 17201 Ph: (717) 262-2183 Fax: (717) 262-2486
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REFERRAL AND INFORMATION FOR SCHOOL BASED OUTPATIENT SERVICES

****WHEN COMPLETE, PLEASE FAX TO OUR REFERRAL DEPARTMENT AT (717) 262-2486****

School Name: _____ School Phone #: (_____)_____-_____

School Contact Person: _____ Date of Referral: ____/____/____

Client's Full Name: _____

Client's Address: _____

SS # _____ - _____ - _____ Gender: M _____ F _____ D.O.B ____/____/____

Primary Insurance Carrier: _____ M.A. or ID #: _____

Group #: _____ Insurance Co. Phone #: (_____)_____-_____

Is there a secondary insurance?: Y _____ N _____ Unknown _____

If any insurance information is not known, Momentum Services will obtain this from the parent/guardian

Are you aware of a Legal Custody Order? Y _____ N _____ If yes, this order will determine who consents to participate in School Based Services.

Father's Name

Mother's Name

**Other Guardian Info*

<i>Address</i>			
<i>Home Phone #</i>			
<i>Work Phone #</i>			
<i>Cell Phone #</i>			

*Other Guardian Relationship to Client: _____

Current Medications: _____

Prescribing Doctor: _____

Reason for Referral: _____

I, _____ give permission for the Shippensburg Area School District to release the above information to Momentum Services, LLC.

Parent/Guardian Signature

Date

Helping Today.....Building Tomorrow