Uplift Counseling Services
222 Chalan Santo Papa · Reflection Center Suite 102 Hagatña, Guam 96910
www.westcare.com · https://uplift.westcare.com/
671- 472-0218 ext. 103

OUTPATIENT REFERRAL FORM

Client Information			
Last Name:	**First Name:**		**M.I.**
Social Security Number:	**Date of Birth:**	**Sex:** ☐ Male ☐ Female	
Ethnicity:	**Interpreter Services Needed:** ☐ **Yes** ☐ **No**	**If yes, in what language:**	
Residential Address:	**City:**	**State:**	**Zip Code:**
Mailing Address: (If different from residential)	**City:**	**State:**	**Zip Code:**
Home Phone:	**Permission to leave a message?** ☐ Yes ☐ No	**Other Phone:**	**Permission to leave a message?** ☐ Yes ☐ No
Employment Status: ☐ Employed ☐ Unemployed ☐ Retired ☐Student		**Employer/ School:**	
Work Phone:	**Permission to leave a message?** ☐ Yes ☐ No	**Email Address:**	
Insurance: ☐ Self-Pay ☐ Medicaid ☐ Medicare ☐ Aetna ☐ SelectCare ☐ NetCare ☐ TakeCare ☐ StayWell ☐ Other: ____			

Emergency Contacts:		
Name:	**Contact:**	**Relationship:**
Name:	**Contact:**	**Relationship:**

Reason For Referral:

____
____
____

Referral Source Information:	
Referring Source: ☐ Self-Referral ☐ Other (Please Specify): ____	
Name of Referring Person:	**Contact Information:**
Services Referred For: ☐ Substance Use Assessment ☐ Substance Use Individual Counseling ☐ Substance Use Group Counseling ☐ Behavioral Health Individual Counseling ☐ Behavioral Health Group Counseling	

Release of Information

I,____________________________________ authorize WestCare Pacific Island, Inc. to share this form with ____________________________________. An additional release of information will be required to discuss treatment.

Client's Signature: ____ Date: __________________

☐ Please check box if patient provided verbal consent.

FOR OFFICIAL USE ONLY BY WESTCARE PACIFIC ISLANDS UPLIFT COUNSELING SERVICES

Date & Time Received:	Received by:
Referral Status: ☐ **Eligible.** Appointment on:_______________	☐ **Ineligible.** Referred to:______________ ☐ **Declined**