DLH Consulting & Psychiatric Services

516 Hawthorn St
Suite #4
Dartmouth, MA 02747

Phone: 774-929-7420
Fax: 508-742-1746
www.dlhconsultant.com

FOR REFERRALS PLEASE FAX COMPLETED FORM TO: (508) 742-1746

Client Registration Form Please (Check All That Apply)

☐ Psychiatric Evaluation/Medication

☐ Psychotherapy

Name: _____ DOB: _____ Soc# _____ Date: _____

Address: _____ Home #:_____
_____ Cell #: _____
Email: _____ Other#: _____

Gender: M/F ____ Ethnicity: _____
Language: _____

Emergency Contact: _____ Rel. _____ Phone: _____
Next of Kin: _____ Rel. _____ Phone:_____

Primary Care Physician: _____ Tel#: _____
Address: _____ Fax#: _____

REFERRAL SOURCE: _____

Primary Insurance: _____ Policy #: _____
Group/ Number: _____ _ Copay:_____
Subscriber: _____ Rel. to Client: _____
Subscriber DOB: _____ Subscriber Soc #: _____

Secondary Insurance: _____ Policy #: _____
Group/ Number: _____ _ Copay:_____
Subscriber: _____ Rel. to Client: _____
Subscriber DOB: _____ Subscriber Soc #: _____

Reason for Referral:
_____
_____

If Medication only referral: Does the patient have ongoing psychotherapist? _____
If yes who?
Name:_____ __ Phone Number_____

Referral must include:

Eval/Bio/Psych/Soc (Psychotherapist) & Copy of Physical/labs & med list (MD)