Behavioral Health Clinic

PSYCHOLOGICAL REFERRAL FAX FORM

Fax: (715) 848-0425

Date: _____ Client Name: _____

DOB: _____ Contact Name: _____ Phone #: _____

Referring Provider: _____ Clinic Name: _____

Referral Coordinator: _____ Phone: _____

E-mail: _____ Fax: _____

Reason for Referral: _____

_____

☐ Mental Health Condition ☐ Support for Medical Condition

(Please include patient demographics with insurance information for all referrals.)

☐ Therapy (Individual / Family / Group) ☐ Psychological Testing ☐ Online Counseling

Clinician/Location Preference (*if no preference, please leave blank*):

Wausau Office:

- ☐ Allyson Ende, Psy.D.
- ☐ Heather Meggers-Wright, Ph.D.
- ☐ Jeffrey Willems, Ph.D.
- ☐ Shannon Schaefer, Ph.D.
- ☐ Timothy Freundl, LPC
- ☐ Ashley Bolling, LPC, SAC
- ☐ Judy Lemke, LPC, LCSW
- ☐ Kristen Brown, LCSW
- ☐ Stacy Luther, LPC-IT

Weston Office:

- ☐ Brian Weiland, Psy.D.
- ☐ Lauri Doepke, LPC, NCC
- ☐ Rachel Zentner, LPC, SAS
- ☐ Jeffrey Willems, Ph.D.
- ☐ Melanie Strand, CSAC, LPC-IT

Plover Office:

- ☐ Heather Meggers-Wright, Ph.D.
- ☐ Rachel Pagel, LPC, CSAC, CS-IT
- ☐ Stacy Luther, LPC-IT
- ☐ Timothy Freundl, LPC

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Confirmed Behavioral Health Clinic Appointment Information:

Date of Appointment: _____ Time: _____

Location: _____ Clinician: _____