



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.

Ashley Bolling, LPC, SAC

Heather Meggers-Wright, Ph.D.

Judy Lemke, LPC, LCSW

Jeffrey Willems, Ph.D.

Kristen Brown, LCSW

Shannon Schaefer, Ph.D.

Stacy Luther, LPC-IT

Timothy Freundl, LPC

Weston Office:

Brian Weiland, Psy.D.

Jeffrey Willems, Ph.D.

Lauri Doepke, LPC, NCC

Melanie Strand, CSAC, LPC-IT

Rachel Zentner, LPC, SAS

Plover Office:

Heather Meggers-Wright, Ph.D.

Stacy Luther, LPC-IT

Rachel Pagel, LPC, CSAC, CS-IT

Timothy Freundl, LPC

Confirmed Behavioral Health Clinic Appointment Information:

Date of Appointment: _____ Time: _____

Location: _____ Clinician: _____

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