

MYCS School Based Therapy Referral

Fax completed referral form and ROI to 412-675-8484
Attn: OPC Intake School Based Therapy Referral

Referred Child Info:

Full Name		Phone Number	
Date of Birth		School	
Date Referred		Referred by: Name/Email/Phone	

Parent/Guardian Information

Parent/Guardian Name		Parent/Guardian Relationship	
Address		Phone Number	

Insurance Information

Name of Insurance			
Member ID #		SS #	
Subscribers Full Name		Client Relationship to Subscriber	

Reason for Referral:

Was SAP offered - Yes No

For internal use only:

Date Received: _____

Contacts:

Reviewed Admission Criteria
Provided Intake Information

Reviewed Insurance Information