



Phone (517)667-0061

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### Therapy Referral Form – Fax to (517) 507-4888

#### Patient Information

Name		DOB		Gender	<input type="checkbox"/> Male	<input type="checkbox"/> Female
Address						
City State					Zip Code	
Phone Number				Medicaid?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Insurance Company	Mclaren, Meridian etc.					

#### Referring Provider Information

Name			
Office Phone		Fax	

#### Client/Patient Signature

I authorize to fax this referral form to GPS – Guide to Personal Solutions at 517-507-4888 so they may contact me regarding my referral to their offices.	
Client Signature	
Date	

GPS Staff

Date Received \_\_\_\_\_ Date Called \_\_\_\_\_

Scheduled with \_\_\_\_\_ Intake Date \_\_\_\_\_