



KRYSTAL CLEAR THERAPY

CLIENT REFERRAL FORM

CLARITY | HEALING | GROWTH

Downtown New Bedford, MA | In-person and telehealth | (508) 452-6159

Complete all known information. Submission begins the referral process but does not guarantee placement.

CLIENT INFORMATION

Client full name

Date of birth

Pronouns (optional)

Parent/guardian (if applicable)

Client/guardian phone

Email

Home address

City / State / ZIP

INSURANCE INFORMATION

Insurance plan

Member ID

Policyholder name

REFERRAL DETAILS

Requested service

☐

Individual

☐

Family

☐

Group

☐

Not sure

Preferred format

☐

In-person

☐

Telehealth

☐

Either

Reason for referral / presenting concerns

Relevant history, diagnoses, supports, or accommodations

SAFETY AND SCHEDULING

Any current safety concerns?

☐

No

☐

Yes

If yes, briefly explain

Best days / times

Language or accessibility needs

REFERRAL SOURCE

Name and organization

Phone

Email

☐ Client/guardian agrees to be contacted by Krystal Clear Therapy.

NOT FOR EMERGENCIES - CALL 911 OR 988 FOR IMMEDIATE HELP

Return through a secure method provided by the practice. A separate Release of Information may be required.