

Adolaize®

Referral Form

Kindly provide the following via call or email:

INTAKES@ADOLAIZE.COM

(443) 219-7878

¹Name: _____

²DOB: _____ / _____ / _____

³ Contact Info: (_____) _____ - _____ Adult Minor

If minor, Parent/Guardian Name: _____

*Informed about referral for services: Yes Not Yet

⁴Insurance Coverage Info: # _____

Medicaid (MA) (or attach copy of card) Unknown

CareFirst (Blue Cross|Blue Shield) UnitedHealthCare Optum Aetna

United Behavioral Health Cigna TriCare Other _____

⁵Referred for: (please indicate all that apply) In Office In School

Counseling/Therapy:

Mood Instability

Stress Management

Anger Management

Grief/Loss

Family Stressors

ADOLAIZE ACADEMY: Realms of Character Summer Sessions

Anxiety Concerns

Behavioral Concerns

Coping Skills

School-related Stressors

SKILLS BUILDING GROUP

Resources:

Group Home Resident

Residential Facility Resident

This awesome reason: _____

⁶Referred by: _____ Your Contact Info: _____