



7 Bristol Ct, Reading, 19610 **Mailing and Practice**
296 W Ridge Pike, Ste 205, Royersford, 19468 **Practice**
610 514 9332 **Fax**
484 706 9465 **Office**

EverlastingWellness.Counseling@gmail.com
<https://everlasting-wellness.clientsecure.me> **Scheduling Portal**

Referral for Everlasting Wellness LLC

Legal Name _____ DOB ____/____/____

Address _____

City State Zip

Phone _____ Email _____

Insurance Company _____

Subscriber's Name _____ DOB ____/____/____

Phone _____ Member ID _____ Sex _____

Specialty Needed (please check all that apply):

<input type="checkbox"/> ADHD	<input type="checkbox"/> Disordered Eating	<input type="checkbox"/> Other _____
<input type="checkbox"/> Anger Management	<input type="checkbox"/> Domestic Abuse	<input type="checkbox"/> Perinatal Disorders
<input type="checkbox"/> Anxiety	<input type="checkbox"/> Fertility/Infertility	<input type="checkbox"/> Postpartum Depression
<input type="checkbox"/> Behavioral Issues	<input type="checkbox"/> Grief and Loss	<input type="checkbox"/> Racial Identity/Justice
<input type="checkbox"/> Bipolar Disorder	<input type="checkbox"/> Marital/Premarital	<input type="checkbox"/> Trauma
<input type="checkbox"/> Child Loss	<input type="checkbox"/> Men's Issues	
<input type="checkbox"/> Depression	<input type="checkbox"/> OCD	

Focusing on (please explain what the individual needs):

_____ _____ _____

Preferred Appointment Dates/Times and In Person or Virtual

Referring Organization and Provider Information:

Would you like to be included on updates for this individual? Yes _____ No _____
If yes, please provide your contact information

