New Life Counseling, PC
227 NW School Street Ankeny, IA 50023-1746
Phone: 515-964-5003 | Fax: 515-225-4016

Member Assistance Program Referral Form

(Please fax this form to our office and the client will receive a call back to set up an intake appointment)

Patient Legal Name:			
Parent/Guardian Name: (if applicable)		**Patient DOB:**	
Patient Phone:		**Patient Email:**	
Patient Address:			

Can we leave a voicemail? ☐Yes ☐No Do you prefer an email or phone call? ☐Email ☐Phone Call

Does the referred patient have private health insurance with a mental health benefit? ☐Yes ☐No

Insurance Provider: *(If known)* ____________________

Services of interest:

☐ Marriage & Premarital
☐ Grief, Loss, Infertility, Depression
☐ Trauma, EMDR, PTSD, Abuse
☐ Addiction (Substance, Pornography)
☐Eating disorder
☐Nutrition & Wellness
☐Family & Parenting
☐Children over 7 years
☐Personal Growth
☐Mood disorders (anxiety, anger, etc)
☐Relationships, boundaries, communication
☐Other (Specify) ______________________
____

Name of referring organization: ____________________

Name of leader referring the potential client (main point of contact): ____________________

Date of the referral: ____________________

Client can expect to be contacted within 5 business days of receipt of this form

For general questions contact the MAP Liaison:

Linda Wilcox, RDN, LD

Linda.newlifecounseling@gmail.com