Referral Form

Email: Support@LeadingEdgeTherapyGroup.com
Phone: (417) 501-9423 | Fax: (833) 523-2374
Website: www.LeadingEdgeTherapyGroup.com

Leading Edge Therapy

1. Patient Information

Name: Date of Birth: Phone:

Email:

Address:

2. Insurance Information

Plan Name: Member ID: Group #:

Policy Holder (if not patient): DOB

3. Reason for Referral (check all that apply)

- ☐ Trauma/PTSD
- ☐ Eating Disorder
- ☐ Substance Use Disorder
- ☐ Chronic Pain
- ☐ Anxiety
- ☐ Depression
- ☐ Insomnia
- ☐ Other:

4. Urgency Level

☐ Routine ☐ Urgent

5. Referring Provider Information

Name: Role/Title:

Organization:

Phone: Fax: Email:

6. Anything else you would like us to know?

7. Signature & Date

Signature: Date:

Please fax completed form to (833) 523-2374 or email to Support@LeadingEdgeTherapyGroup.com.
We will contact your patient within 24-48 hours of receiving this form.