Limitless Counseling Services (LCS) LLC
2670 N. Columbus Street Suite F &G
Lancaster, Ohio 43130
Phone: (740) 901-1231
Fax: (740) 901-3021

Referral Form

****Please send releases of information, demographic information, evaluations, and/or any pertinent collateral information when/if appropriate to assist with care.****

Today's Date: _____ **Request: ___Urgent ___Routine**

Client Name: _____ DOB: _____Age: _____

Client Phone: _____ Client SSN: _____ *(To verify insurance)*

Address:_____

Email:_____ Previous Client: _____ Yes _____No

Primary Insurance _____

Member ID: _____

Group # _____

Secondary Insurance _____
(if applicable)

Member ID: _____

Group # _____

Ins Policy Holder Information (Name, DOB, SSN): _____

Appointment Preference: *(Mark all that apply)* ***Please understand that this is considered, not guaranteed. ****

___ Monday
___ Tuesday
___ Wednesday
___ Thursday
___ Any Day

___ Mornings
___ Evenings
___ Afternoons
___ Anytime

___ In-Person
___ Teletherapy
___ Both (In-person or Teletherapy)

Reasons Seeking Treatment: *(Mark all that apply)*

____ Depression/Depressed Mood
____ Abuse/Neglect
____ Pending Divorce/Dissolution
____ School/Work-Related Issues
____ Mandatory Referral from Employer
____ EAP Referral or Ohio ASSIST
____ Court Ordered Treatment
____Other: _____

____ Anxiety
____ Substance Use
____ Stress
____ ADD/ADHD
____ Relapse Prevention
____ Dual Diagnosis
____ Aftercare
____ Referred by Doctor

____ Trauma
____ Life Transitions
____ Grief Issues
____ Provider Referred
____ Relationship Issues
____ Skill Building
____ Medication Assisted Tx

Additional Information/Comments:_____

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