



Rainy Day Psychology

SERVICE REFERRAL FORM

Washington State Labor & Industries Claim

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CLAIM INFORMATION		
Claim Number: _____	Date of Injury: _____	Date of Referral: _____
PATIENT INFORMATION		
Patient Name: _____	Date of Birth: _____	
Phone (Primary): _____	Phone (Secondary): _____	
Preferred Contact Method: <input type="checkbox"/> Phone <input type="checkbox"/> Email <input type="checkbox"/> Mail <input type="checkbox"/> Interpreter needed - Language: _____		
CLAIMS MANAGER INFORMATION		
Name: _____	Phone: _____	
Email: _____	Fax: _____	
REFERRING PROVIDER INFORMATION		
Provider Name: _____	Phone: _____	
Clinic/Practice: _____	Fax: _____	
INJURY & DIAGNOSIS INFORMATION		
Body Part(s) Injured: _____		
Primary Diagnosis/ICD-10: _____		
Accepted Conditions: _____		
REASON FOR REFERRAL		
<input type="checkbox"/> Pain Management <input type="checkbox"/> Depression/Anxiety <input type="checkbox"/> PTSD <input type="checkbox"/> Sleep Issues <input type="checkbox"/> Return to Work Support		
<input type="checkbox"/> Coping Skills/Adjustment <input type="checkbox"/> Substance Use <input type="checkbox"/> Other: _____		
Additional clinical information/specific concerns: 		
AUTHORIZATION STATUS		
<input type="checkbox"/> Authorization Approved <input type="checkbox"/> Authorization Pending <input type="checkbox"/> No Authorization yet		
Auth Number (if applicable): _____ Authorized Sessions: _____		

For Office Use Only: Date Received: _____ | Initial Contact Date: _____