Referring Provider/Source Info

Referring Provider Name: _____

Practice/Organization: _____

Role (OB, PCP, Therapist, School Counselor, etc.): _____

Phone Number: _____

Email: _____

Preferred Contact Method: ☐ Phone Call ☐ Email

Permission to Communicate: ☐ Yes ☐ No

How did you hear about Bloom? _____

Client Demographics

Client Full Name: _____

Preferred Name & Pronouns: _____

Date of Birth: _____

Phone Number: _____

Email: _____

City/State: _____

Preferred Contact Method: ☐ Phone Call ☐ Text ☐ Email

Insurance/Payment

Insurance Carrier: _____

Member ID (Optional): _____

Self-Pay? ☐ Yes ☐ No

Deductible Concerns/Financial Sensitivity (If known, optional): _____

_____

Reason for Referral

Primary Reason for Referral (check all that apply):

- ☐ Perinatal/postpartum mental health
- ☐ Anxiety
- ☐ Depression
- ☐ OCD
- ☐ Trauma/PTSD
- ☐ ADHD
- ☐ Medication management
- ☐ Hormone concerns
- ☐ Fertility / pregnancy / postpartum support
- ☐ Parenting / family support
- ☐ Other: _____

Brief description of current concerns:

Urgency & Safety Screen

Is this referral time-sensitive? ☐ Yes ☐ No

Any current safety concerns the provider is aware of? ☐ Yes ☐ No

If yes, please briefly describe:

*Please note: this does not replace emergency services.. If emergency services are necessary, please have patient seek immediate medical help.

contactus@bloomwomenswellness.org
515 - 499 - 4959
10542 Justin Drive, Urbandale, 50322
bloomwomenswellness.org

Preferred Services at Bloom

Helps route internally right away.

- ☐ Individual therapy
- ☐ Medication management
- ☐ Hormone consultation / labs
- ☐ Psychological testing
- ☐ Group therapy / support group
- ☐ Unsure – please advise

Client Preferences

Provider gender preference (if any): _____

In-person or Telehealth preference: _____

Availability (days/times): _____

Any cultural, perinatal, or life-stage considerations you want us to know:

_____

Consent Acknowledgement

☐ I have the client's permission to submit this referral and share the above information with Bloom Women's Wellness for the purpose of care coordination.

Referring provider signature: _____

Date: _____

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