Leslie Ann Shields, M.S.

L.A.'s WellBeing Center

Healthy-Living Coaching, Counseling, Training

106 E.24th St. Houston, TX 77008 PH: 832.858.1411/ FAX: 713-422-2428/ Appt Line 832-409-3242

Self or Health Care Referral

Today's Date: ______________________________ I learned about your services from:__________________________

Referrer* (include if self):____________________ Patient Name (Print clearly):______________________Age:______

Apprx: Time TX'g Patient:______________________________ Referrer PH#*: __________Referrer E-mail*: ___________________

Referrer Fax#*: ___________________________ Contact preference for Referrer:___________________________

Work E-mail*:___________________________ Address*: ______________________City:__________St:____Zip:_________

*May we contact you@above PH#/Email? Yes/No *May we contact you@above PH#/Email? Yes/No (*required info)

Situation/Diagnosis: (include codes if applicable): ______________________________________

(If self referral, date of last ann-physical:______w/ DR.____________ recommended w/in past 6-10m)

Is Situation/DX Exacerbated by Stress: YES / NO **; Possibly Affecting Breathing Pattern:** YES / NO

Current Top (3) Symptoms Reported: ____

Psychotropic Medication RX'd (Please list dosing & start date): ____________________________

Other Medications:____

I am interested in the following: (Check one below):

- ○ **Assessment of Stress/Risk Factor Profile:** (Determines Appropriateness for Healthy Living Education & Training for Preventative Medicine or Risk Factor Reduction vs Counseling and Psychotherapy Services.) **If Pre-Surgical Candidate Screening (circle one): Medical / Dental / Bariatric. Please list procedure:** ____

- ○ **Cognitive Skills Training** (circle applicable): **Deficits are Developmental /AorTBI-related** Attention / Problem-Solving / Working Memory / Auditory-Visual Motor Skills / Processing Speed Date of Latest NeuroPsych Eval: (required):____________________________

- ○ **Training for Optimizing Performance or Behavior Change Services for Health-Risk Factor Reduction** (indicate applicable) **:** Physical Symptoms of:_____________ /Behavioral Modification for _____________/Emotional Symptoms of: _______________ Biofeedback Training for (circle) Headache, TMJ/D, IBS, Stress, Anxiety, Pain Management, other____________

- ○ **Counseling / Psychotherapy:** (Patient requests and/or Dr. recommends due to observed distress level / medication prescribed): **Circle requested/recommended approach(es):**
  - ___Cognitive/ Restructuring
  - ___ Relaxation/Stress Management Training
  - ___ Insight-Oriented Therapy
  - ____Symptom-focused Psychoeducation
  - ____ Supportive Maintenance Counseling
  - ____ Substance Abuse Screening/Intervention
  - ___Lifestyle/Change Planning & Support of following Behavior: ______________________________

  for reducing exacerbation of this medical condition: ____________________________________

- ○ **I have an M.D. follow-up in _____________#of weeks for review of:____________________**

Other/Special Request(s): ____

Referrer Signature: _________________**Printed Name:** ______________________ **Date:** __________

I, the client or guardian of client below, authorize the release of medical/personal information necessary for processing of insurance benefit verification, consultation & referral follow-up to Leslie Ann Shields, PLLC. **Please Fax to"L.A."@: 713-422-2428/or use You Send It**

Name of Client/ Patient: ____ **Date:** ___________________

Signature of Client or Guardian/Parent: ____

Printed Name of Guardian/Parent: ____