LITTLE LOVE NOTES, LLC

2134 Espey Court, Ste 3
Crofton, MD 21114
(443) 292-6760 (Tel)
(443) 577-4600 (Fax)
Info@littlelovenotesllc.com

LLN REFERRAL FORM

Please answer all questions to expedite the referral process. Please email this form to info@littlelovenotesllc.com.

Please state which psychotherapy service(s) you are referring this individual for:

- ☐ Individual Psychotherapy
- ☐ Couples/ Family Therapy
- ☐ Group Therapy
- ☐ Medication Management
- ☐ Psychiatric Rehabilitation Program (PRP)
- ☐ Substance-Use IOP/OP

APPLICANT INFORMATION:			
First Name:	M.I.	Last Name:	
Address:			
City:	State:	Zip Code:	
Cell Number:	Home Number:	Work Number:	
Birthdate:	Age:	Gender:	Race:
Social Security Number:	Medicaid Assistance Number:		
Emergency Contact's Name:	Relationship:	Telephone Number:	

DEMOGRAPHIC QUESTIONNAIRE FOR MARYLAND MEDICAL ASSISTANCE:	
Is the patient of Hispanic or Spanish origin:	Is the patient a hurricane victim?:
Marital Status:	
Living Situation:	
Employment Status:	
Pregnant?	Participated in a self-help group in the last 30 days?
Highest level of education:	Number of arrests within the last 30 days:
Is the patient a Veteran? If yes, which war:	

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Specify the time for military service:

- ☐ Never in military
- ☐ On active duty
- ☐ Veteran in combat 6-12 months ago
- ☐ Veteran-never in combat
- ☐ Veteran in combat less than 6 months ago
- ☐ Veteran in combat for more than 12 months

Is the patient visually impaired?	Is the patient hard of hearing?	Any other disability status?

REFERRING SOURCE:		
Name:	Credential(s):	Title:
Agency:	Address:	
Telephone Number:	Fax Number:	
Email Address:		

Signature Date