Life In Harmony
Music Therapy, LLC

LIFE IN HARMONY MUSIC THERAPY, LLC

Referral Form

Submit via email (admin@lihmt.com) or fax (414-377-3353)

CLIENT INFORMATION

Client's Name: | Date of Birth: | Social Worker/Coordinator: *(if applicable)* | County: | Funding Program: *(if applicable)* | Referral Date:

Client's Current or Primary Address:

Name(s) of Parent(s)/Guardian(s) at This Address: *(if applicable)*

Home/Cell Phone:

Email: *(if applicable)*

Best contact Method(s): ◯ Phone ◯ Email ◯ Text

Does this individual live at a second location/residence? ◯ No ◯ Yes

If yes, please list name(s) and contact information for additional parent(s)/guardian(s) living at the secondary location/residence. *(if applicable)*

INSURANCE INFORMATION

Does the client have private health insurance? ◯ No ◯ Yes

If yes, what health plan?

REASON FOR REFERRAL AND PRESENTING CONCERNS

Medical Diagnosis:

Cognitive Needs, Life Skills Development, Safety Skills Needs:

- ☐ Memory Recall
- ☐ Attention (Sustained, Alternating, etc.)
- ☐ Executive Functioning Skills
- ☐ Independence of ADLS
- ☐ Sequencing
- ☐ Auditory Processing
- ☐ Arousal/Vigilance/Orientation
- ☐ Sensory Tolerance
- ☐ Following Directions
- ☐ Other

Social, Emotional, and Community Integration Needs:

- ☐ Social Engagement
- ☐ Understanding Social Rules/Norms
- ☐ Understanding Body Language
- ☐ Self-Awareness
- ☐ Social Reciprocity/Interaction
- ☐ Effective Expressive Communication
- ☐ Receptive Communication
- ☐ Identifying Emotions
- ☐ Effective Coping/Calming Strategies
- ☐ Healthy Peer & Family Relationships
- ☐ Navigating/Tolerating Transitions
- ☐ Positive Leisure Skills
- ☐ Other

Physical Needs:

- ☐ Coordination or Balance
- ☐ Purposeful Motor Movements
- ☐ Motivation during Home Program
- ☐ Pain Management
- ☐ Strength/Endurance
- ☐ Dexterity
- ☐ Range of Motion/Muscle Relaxation
- ☐ Oral Motor Control
- ☐ Respiration Rate/Regulate Breathing
- ☐ Other

Are there additional presenting concerns or additional areas of need? Is there additional important information we should know?

TYPE OF SERVICE, FREQUENCY, AND DURATION

Service Type: ☐ Individual ☐ Small Group *(if available)*

Duration/Frequency: ☐ 30 min/week ☐ 45 min/week ☐ 60 min/week ☐ 45 min/EO week ☐ 60 min/EO week ☐ Other/I'm not sure

CLIENT AVAILABILITY/SCHEDULING INFORMATION

Please select all general windows of availability.

Mondays (9:00 AM - 7:15 PM)

☐ Morning ☐ Early Afternoon ☐ After-School ☐ Early Evening

Tuesdays (9:00 AM - 7:15 PM)

☐ Morning ☐ Early Afternoon ☐ After-School ☐ Early Evening

Wednesdays (9:00 AM - 7:15 PM)

☐ Morning ☐ Early Afternoon ☐ After-School ☐ Early Evening

Thursdays (9:00 AM - 7:15 PM)

☐ Morning ☐ Early Afternoon ☐ After-School ☐ Early Evening

Fridays (9:00 AM - 7:15 PM)

☐ Morning ☐ Early Afternoon ☐ After-School ☐ Early Evening

Saturdays (9:00 AM - 1:00 PM (Currently), Future availability may vary)

☐ Morning ☐ Early Afternoon *(if available)*

Please list any specific information pertaining to scheduling windows noted above (i.e scheduling concerns, programming schedule, times to avoid, transportation, etc.).

Please list any information pertaining to school or vocational programs the individual is enrolled in (i.e. School/program attended, school release time, vocational hours, etc.).

LOCATION: Primary site at LIH Clinic - 860 Mill Street N, Suite 2, West Salem, WI 54669

Alternatives available if deemed necessary for medical reasons, transportation issues, physical distance, etc. include the following options:

☐ LIH Clinic ☐ Mobile Studio/Songbird Express *(if available)* ☐ Home/Client Residence

☐ Other

TO SUBMIT:

1) Save PDF as "Music Therapy Referral for Initials" (i.e. Music Therapy Referral for AS)

2) Email to admin@lihmt.com OR fax to 414-377-3353.

Thank you for utilizing music therapy to address the needs of the individuals you care for and serve.