



Phone: 443- 229-7029 | Mobile: 443-449-1908 | Fax: 443-247-2501 | Email: dlaitegmhs@hotmail.com
Address: 107 Beacon Road, Middle River, MD 21220

Referral Form

Referrer Information

- Referrer Name: _____
- Organization (optional): _____
- Phone Number: _____
- Email Address: _____

Client Information

- Client First Name / Initials (optional): _____
- Brief Reason for Referral: _____
- _____
- _____
- _____
- _____
- Preferred Contact Method (Phone / Email): _____

Consent

I confirm that I have permission to initiate this referral and understand that detailed clinical information should not be submitted through this form.

Signature (Optional for print form): _____

Date: _____

Submission Instructions

To protect client privacy, please submit completed forms via:

- Secure Email: dlaitegmhs@hotmail.com
- Fax: (443) 247-2501

Do not send highly sensitive information through unsecured email unless encrypted. For emergencies, call 911 or go to the nearest emergency room.

For D-Laite Group Use Only

- Date Received: _____
- Intake Staff: _____
- Follow-up Scheduled: Yes No