



**Referral for Services**

**Thank you for your referral. Please discuss the nature and intent of this referral with your client. We will contact the client to schedule an appointment.**

Referral Date \_\_\_\_\_ Referral Source \_\_\_\_\_ (name and agency)  
Referral Address \_\_\_\_\_ Referral Phone \_\_\_\_\_ Referral Fax \_\_\_\_\_

Client Name \_\_\_\_\_ Date of Birth \_\_\_\_\_ Gender \_\_\_\_\_  
SS# (if known) \_\_\_\_\_ Type of Insurance (if known) \_\_\_\_\_  
Residing with \_\_\_\_\_  
Custody Plan \_\_\_\_\_  
Address \_\_\_\_\_  
Contact Home Phone \_\_\_\_\_ Contact Alternate Phone \_\_\_\_\_  
Email address \_\_\_\_\_  
Other Contact Information \_\_\_\_\_  
\_\_\_\_\_

Presenting Comments/Concerns \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Referral Services Requested (check all that apply)

- Mental Health Assessment
- Individual Counseling
- Family Counseling
- Group Counseling
- Substance Use Assessment
- Substance Use Counseling
- Case Management Services