OHIO FAMILY COUNSELING
AND CONSULTATION, LLC

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
- ○ Pain Management Program

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