COUNSELING REFERRAL FORM

Date of Referral: ____/____/_____ **Date of First Scheduled Appt:____/____/____**

Identifying Information:

Client's Name: ______________________________ **Age:** _____ **Transition Age Youth? Y/N D.O.B.** ___________

Address:

City: ________________________ **State**: _______**Zip:** __________ **Email:** ____

Daytime Number: ( ) __________________________ **Home/Other**: ( )

Social Security Number:

Race: ___ **Ethnicity:** ________ **Marital Status**: _________ **Gender**: _____ **Current Level of Education:** ______________

Insurance Type: ____________________________ **Medicaid #:**

Primary Insurance Holder's Name and D.O.B.: ________________________________

Applicable Copayment: $ _________

Private Insurance Group #:___________________________ **Private Insurance Member #:**

Parent/Guardian: __________________________________ **Living Situation:** _____________________________________

Does the Parent/Guardian have legal custody of the minor? YES NO N/A

If they are an adult, do they have a legal guardian? YES NO N/A

If parent does not have custody, please provide custodial information:

Name: ____ **Phone:** ___________________

Address: ______________________________________ **City:** ________________ **State:** _______ **Zip:** __________

Employment Status: ___________ **# of Arrests in past 30 days:** ___________ **Veteran: YES/ NO If so which war?** ______________

Referral Information:

Reason for Referral *(Client Needs and Presenting Problem)*

____

____

Preferred day/time of appointment: ____

Other Preferences: ____

Suicide Risk: ___ **Danger to Self or Others:** ___ **Urgent/Critical Medical Condition:** ___

Immediate Threat(s): _____

Past Psychiatric Admission(s): YES NO N/A **Previous Outpatient Treatment**: YES NO N/A

Current Outpatient Provider: _______________________________________ **Phone:** _________________ **AXIS I** _____________________ **AXIS II** ____________________ **AXIS**

III ________________   AXIS IV ______________

Referral Source Printed Name & Institution (IF APPLICABLE):

____

Referral Source Signature: _________________________________   Date: ______________

Authorization #__________________ Sessions _____ Authorization Dates from ________ to _______
Intake Appt. Therapist: ____________________________ Date of Intake: _________ S/NS: ________

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"ENCOURAGING PERSONAL, Relationship, and Spiritual Growth"