LUKAS COUNSELING
THERAPY ■ CASE MANAGEMENT ■ PSYCHIATRY

Email: referrals@lukascounseling.org | Fax 561-430-2039 | www.LukasCounseling.org

THIS FORM IS AVAILABLE TO BE COMPETED ON OUR SECURED & HIPAA-COMPLIANT WEBSITE

NEW CLIENT REFERRAL FORM

Please indicate what you're looking for (Required):

- ☐ Counseling/Therapy
- ☐ Case Management
- ☐ Medication Management *

* All medication management clients are required to ALSO have Counseling services as part of the treatment of care.

Where are you located? (Required)

- ☐ Central (Orange/Osceola/Seminole counties)
- ☐ Coastal (Everywhere else in Florida) – **County:** _____

Last Name_____ First Name _____ Middle Initial: _____ Phone # _____

DOB ____/____/____ SS# _____ Sex: M | F Email _____

Address _____ City _____ Zip _____

Reason(s) for Referral (check or write-in):

___Anxiety
___Inattention/Hyper
___Verbal Aggression
___Substance Abuse
___Sexual Acting-Out
___Trauma / Grief
___Physical Aggression
___Post Adoption Issues
___Dependency
___Psychosomatic
___Recent Baker Act
___Low Self Esteem
___Depression
___Social Skills
___Non-Compliance
___Bullying
___Family Issues
___Defiance/Disrespect

Referral & Client Questions:

Has the client had mental or behavioral health services in the last 12 months? __N __Y (Where :_____)

I am requesting a specific therapist: _____

- ☐ I prefer Telehealth.
- ☐ I prefer in-person, but Telehealth is OK if needed.
- ☐ I need in-person counseling/therapy.
  - ☐ I am willing to wait if there's a wait for in-person.

DJJ Involvement? ___Y ___N
DCF Involvement? ___Y ___N
(If the child is involved with Child Welfare Case Management, please send Shelter Order. Intake packet will be sent to DCM)

Client's primary language: _____ English ___ Spanish ___ Other

If child > School's Name _____

Insurance:

Medicaid ID Number: _____
If Medicaid # is not available, SSN must be provided above.

Medicaid Insurance Plan:
[__] Staywell [__] Sunshine [__] Beacon [__] United
[__] CMS [__] Magellan [__] Straight-Medicaid [__] Prestige
[__] Aetna Better Health [__] Humana [__] Simply [__] Other

[__] I also have a commercial plan: _____

Who is Making the Referral?

Name: _____

- ☐ I am the client/parent/guardian.

CONSENT TO TREAT. If you ARE the client/parent/guardian, I authorize and give consent for the above named individual to participate in mental health / behavioral health services and treatment through our agency, and I have read and agreed to all consent terms located on our website and found at www.lukascounseling.org/consents.

Signature: ***X*** _____

If child does not reside with parent, then legal guardian must provide legal documentation supporting the ability to consent to treatment. This includes step-parents, grandparents and other caregiver.

If you're not the client/parent/guardian, then provide us with:

Referring Agency: _____

Email: _____