



COUNSELING REFERRAL

Please select the type of counseling:

Insurance accepted: Husky/Medicaid; Anthem; Aetna; Self-pay

- Telehealth Counseling** via secure video (Statewide)
 IN HOME Counseling *not available during pandemic **IN OFFICE** Counseling (in Cheshire)

DATE OF REFERRAL: _____

NAME OF PERSON MAKING REFERRAL: _____

Telephone number of person making referral: _____

EMAIL: _____

PLEASE ATTACH A COPY OF A SIGNED RELEASE OF INFORMATION

REFERRAL FOR:

- INDIVIDUAL COUNSELING FAMILY COUNSELING
 SUPPORTIVE PARENTING: A Future without Violence
 OTHER: _____

NAME OF CLIENT: _____ **DATE OF BIRTH** _____

Insurance Type: Husky/Medicaid or Private: _____ **Insurance ID #** _____

ADDRESS WHERE CLIENT LIVES: _____

Contact information (name, telephone number) where client lives: _____

GUARDIAN NAME: _____

GUARDIAN Telephone: _____

GUARDIAN EMAIL(if applicable): _____

ANY ADDITIONAL INFORMATION: _____

For More information: www.ctkidsmatter.com

Telephone: (203) 599-1492

FAX: (203) 433-0669

Email to: intake@ctkidsmatter.com