CAROLINA'S COMPASSIONATE COUNSELING

11920 Fairway Lakes Dr. Ste 3
Fort Myers, FL 33913

PEACE IN YOUR MIND BALANCE IN YOUR BODY HEALING IN YOUR SPIRIT

Referral Form

Name: _____ Age: _____ DOB: _____ Sex: [ ] Female [ ] Male

Ethnic Client Origin: _____ Language Client Speaks: _____

Referred by: _____ (please print)

Address: _____ City: _____ State: _____ Zip: _____

Home Phone: _____ Cell Phone: _____

Health Insurance: [ ] Yes [ ] No If yes please specify the provider: _____

Is the client, to your knowledge, currently suicidal or homicidal? [ ] Yes [ ] No

Has the client, to your knowledge, ever been suicidal or homicidal? [ ] Yes [ ] No

If yes, please explain: _____

_____

Do you suspect the client may be involved in substance abuse? [ ] Yes [ ] No

Was there prior treatment/counseling for substance abuse? [ ] Yes [ ] No

If yes, please explain: _____

_____

Are there any present, or previous, investigations ongoing with the Department of Children and Families for abuse, neglect, or abandonment? [ ] Yes [ ] No

If yes, please explain: _____

_____

Allegation: _____

_____

Mental Health Issues (Prior and Present)

Diagnosis: _____

Prior counseling: [ ] Yes [ ] No

If yes, please write the agency or provider: _____

_____

Present medication: _____

Summary of the presenting problem: _____

_____

_____

Additional information: _____

_____

_____

Recommendations: _____

_____

_____

_____

Referral Source Printed Name Date

_____

Referral Source Signature Date

Please send completed form to:

E-mail: Info@carolinascompassionatecounseling.com

Fax: 239 - 203 - 2398