REVIVE 180 COUNSELING REFERRAL FORM

Name: ____

Date of Birth: ________________ **Gender:** _________ **Legal guardian** ☐ **Yes** ☐ **No**

☐ **Self-Referral**

☐ **Family Referral (Name & Phone)** ____

☐ **Agency Referral (Agency, Contact Name, Phone)** __________________________________

____

Private Pay ☐ **Yes** ☐ **No**

Insurance(s) ☐ **Yes** ☐ **No** **(Name of Company)** ____________________________________

Primary phone number for scheduling: ____

Secondary phone number for scheduling ____

Email address for intake documentation: ____

Brief description of current mental health needs or behavioral concerns:

____

____

____

____

____

____

Date Received: __________________ **Staff Receiving:** _____________________________