# Arches Counseling and Trauma Treatment

## therapeutic Breathwork group referral

| | | |
|---|---|---|
| client's name | | pronouns |
| address | | |
| phone | okay to text? Y N | email |
| referred by | referral contact phone | |
| referral contact email and mailing address | | |

TO THE LICENSED PROVIDER: Your client intends to register for a therapeutic Breathwork group. For information, scan code below. Please email with any questions. If you endorse this activity for your client, please complete and return this referral to hillary@archesctt.com.

| |
|---|
| current diagnosis(es) |
| current clinical goals |
| somatic manifestation of trauma (eg chronic illness/pain, insomnia) |
| What medical interventions are you aware of? |
| What physical limitations are you aware of? |
| How does this client get "stuck" in therapy? |
| What else should I know? |

clinician/PCP signature _____ date _____

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