

**Referral Form**

**2220 Oretha Castle Haley Blvd. New Orleans, LA. 70113 Ph. (504) 373-4244 a.mcfarland@ontherightpathnola.com**

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| **Referring Agency** |  | | **Phone** |  | | |
| **Location** |  | | **Email** |  | | |
| **Completed by** |  | **Phone** |  | | **Date** |  |

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| **Client Information** | | | |
| **Last name** |  | **First name** |  |
| **Date of birth** |  | **Gender/gender identity** |  |
| **Preferred name** |  | **Race** |  |
| **Guardian name** |  | **Guardian relationship** |  |
| **Client’s address** |  | **Cell phone** |  |
|  | **Home phone** |  |
|  | **Work phone** |  |
|  | **Email** |  |
| **Referral diagnosis if applicable** |  | | |
| **Primary Care Physician/number** |  | | |

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| **Additional information** | | | |
| **School** |  | | |
| **Educational concerns** | | |  |
| **Forensic history if applicable** | |  | |
| **Contact for Education/Forensic** |  | | |

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| **CONSENT TO RELEASE INFORMATION Read with client/caregiver and answer any questions before obtaining signature.** | | | | | |
| **The signatures below serve to certify that the client understands the purpose of this referral & disclosure of information to the listed agency is to ensure the safety & continuity of care among service providers seeking to serve the client. The referring agency has clearly explained the referral process to the client & has listed the information that is to be disclosed. By signing this form, the client and/or their guardian authorizes this exchange of information.** | | | | | |
| **CLIENT**  **SIGNATURE** |  | **CAREGIVER**  **SIGNATURE** |  | **DATE** |  |

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| **Please attach any additional information that may be relevant to providing appropriate services to client** |