Outpatient Recreational Therapy
Mental Health Referral Form

Please complete this form and submit via info@togetherjust.com or Fax 539-444-7059

Date of referral: _____

Referring person: _____ ____Self-referred

Agency name: _____ Phone number: _____

Client Name (First, Last): _____

Client date of birth: _____

Phone number: _____

FOR MINORS ONLY
Parent/legal guardian Name (First, Last): _____

Relationship to child: _____

Phone number: _____

Email: _____

PHYSICIAN INFORMATION (if applicable)

Physician name: _____

Diagnosis (if applicable): _____

Address: _____

Phone number: _____

Physicians orders for Recreational Therapy services? ___YES ____NO

Referral Requests

Please tell us a little bit about what you would like your child/client to gain from Recreational Therapy services.

We reserve the right to refer you to other services we feel would better serve you.

Service type

- ☐ Individual Therapy
- ☐ Group Therapy
- ☐ Parent Education

Cognitive Goals

- ☐ Problem Solving
- ☐ Decision Making
- ☐ Communication
- ☐ Orientation
- ☐ Executive Functioning
- ☐ Memory
- ☐ Attention to task
- ☐ Following direction
- ☐ Judgment
- ☐ Reduction of disturbing behaviors

Community Integration

- ☐ Accessibility
- ☐ Transportation
- ☐ Resource Awareness & Utilization
- ☐ Planning skills
- ☐ Safety in community settings
- ☐ Needs assessment
- ☐ Home modification

Lifestyle Goals

- ☐ Relaxation
- ☐ Stress management
- ☐ Family education
- ☐ Assertiveness Training

Lifestyle Goals Cont.

- ☐ Values clarification
- ☐ Leisure education
- ☐ Leisure skills development
- ☐ Adaptive recreation skills training

Psychosocial Goals

- ☐ Social Skills development
- ☐ Social pragmatics
- ☐ Coping mechanisms
- ☐ Situation analysis
- ☐ Attention deficit
- ☐ Frustration tolerance
- ☐ Task management
- ☐ Time management
- ☐ Crisis management
- ☐ Coping skills
- ☐ Anxiety reduction
- ☐ Self-esteem
- ☐ Body image
- ☐ Adjustment to disability
- ☐ Boundaries
- ☐ Self-awareness
- ☐ Impulse control
- ☐ Self-advocacy
- ☐ Emotions/feelings identification
- ☐ Mindfulness

Please share any additional goals or requests you would like to have addressed:

HEALTH CARE PROVIDERS ONLY

Thank you for completing our referral form.

Please send all information to info@Togetherjust.com and you will be contacted within 3 business days

Clients goals:

Clients current progress towards meeting goals:

Propensities/risks/cautions:

Recommendations:

- ☐ **Individual therapy**
- ☐ **Group therapy**
- ☐ **Parent education**
- ☐ **Other _____**

Additional information:

Feedback required:

- ☐ **Intake report**
- ☐ **Assessment report**
- ☐ **Progress report _____x1 monthly _____x1 Bi-monthly**
- ☐ **Discharge report**

Provider signature: _____ Date: _____