Community Wellness
Counseling & Support Services, LLC

Referral Form

Date: _____ **Referral Source:** _____ **Contact Info:** _____

Name: _____ DOB: _____ ☐ Male ☐ Female

Address: _____ City/State/Zip: _____

Phone: _____ SSN: _____ Medicaid #: _____

Insurance Policy Name, Number/Group ID: _____

Parent or Legal Guardian Contact (if under 18): _____

Reason for Referral / Concerns:

_____

_____

_____

_____

_____

Services Requested (check all that apply):

☐ Individual Therapy	☐ Medication Management	☐ Infant Mental Health Counseling
☐ Family Therapy	☐ Domestic Violence Issues	☐ Play Therapy
☐ Group Therapy	☐ Parenting Classes	☐ Grief Therapy
☐ Anger Management	☐ ADHD Evaluation	☐ Psychiatric Evaluation

Is client receiving any other counseling services? ☐ Yes ☐ No

If yes, where and by whom? _____

Is client receiving any other community based services? ☐ Yes ☐ No

If yes, where and by whom? _____

Are services mandated by court? ☐ Yes ☐ No Pending Charges? ☐ Yes ☐ No

If yes, court date? _____

Please Email Form to: **cwcssbehavioralhealth@gmail.com**	**Please Mail Form to:** **12958 Collins Hill Lane Bristol, FL 32321**	**Please Fax Form to:** **(850) 643-5066**
OFFICE USE ONLY: Date Received:		Meets Eligibility Requirements: ☐ Yes ☐ No