**REFERRAL FORM**

Thank you for choosing to make a referral to CWCSS. It is our highest compliment of trust. CWCSS will continue to update you as services progress. If you require additional assistance, please call (850) 643-1033 and ask for the Referral Coordinator.

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| --- | --- | --- |
| **Date:** | **Referral Source:** | **Contact Number:** |
| **Organization:** | **Email Address:** |
| Have you contacted the client and/or legal guardian about your concerns and this referral to CWCSS?  **Y N** |

|  |  |  |  |
| --- | --- | --- | --- |
| **Client Legal Name:** | **Preferred Name:**  | **DOB:**  | **Gender:** |
| **Address:** | **City & Zip Code:** | **SSN** (for insurance purposes only): | **Race:** |
| **Home Phone:** | **Cell Phone:** | **Email:** |
| **Legal Guardian** (if applicable)**:** | **Relationship:** |
| **Emergency Contact:** | **Relationship:** |

|  |  |  |
| --- | --- | --- |
| **Insurance:** | **Member ID#:** | **Effective Date:** |

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| **Reason for Referral/Concern (include any preferences):** |
| Services Requested (Check all that apply): |
| [ ]  Individual Therapy | [ ]  Family Therapy | [ ]  Group Therapy | [ ]  Psychiatric Evaluation |
| [ ]  ADHD Evaluation | [ ]  Domestic Violence Issues | [ ]  Anger Management | [ ]  Medication Management |
| [ ]  Play Therapy | [ ]  Parenting Classes | [ ]  Grief Therapy | [ ]  Targeted Case Management |
| [ ]  Infant Mental Health | [ ]  Supervised Visitation | [ ]  Substance Abuse |
| Are services mandated by court? Y N If so, please provide an email monthly reports be directed to:  |
| Preference for service location: [ ] Home [ ]  Office [ ]  Telemedicine [ ]  School**: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_** |
| When is client available for sessions, please list multiple times/days? |