**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** | | |

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| --- | --- | --- | --- |
| **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:** | |

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| **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? | | | |