COMMUNITY WELLNESS
Counseling & Support Services

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.

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:**

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	☐ Art Therapy
☐ Infant Mental Health	☐ Supervised Visitation	☐ Substance Abuse	

Are services mandated by court? Y N If so, please provide an email or fax number:

Preference for service location: ☐Home ☐ Office ☐ Telemedicine ☐ School**:** _____

When is client available for sessions, please list multiple times/days?

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Customer service is our 1st priority, because You are the reason we are here