HOUSE OF SHALOM

THERAPEUTIC SERVICES

Come as you are. Become who you've always been.

CLIENT REFERRAL FORM

REFERRING PROVIDER INFORMATION

Referring Provider Name: _____

Practice / Organization Name: _____

Phone: _____ **Fax:** _____

Email: _____ **Date:** _____

CLIENT / PATIENT INFORMATION

Client Name: _____ **Date of Birth:** _____

Phone: _____ **Email:** _____

Preferred Contact Method: ☐ Phone ☐ Email ☐ Either

OK to Leave Voicemail / Detailed Message: ☐ Yes ☐ No

REASON FOR REFERRAL

Service(s) Requested: ☐ Cherry AADI Assessment ☐ Individual Therapy ☐ Both

Presenting Concerns / Reason for Referral:_

Relevant Diagnoses / History (if known):

CONSENT TO RELEASE INFORMATION

By signing below, the client (or legal guardian) authorizes the referring provider named above to share the information on this form with House of Shalom Therapeutic Services for the purpose of coordinating a referral for care.

Client Signature: _____ **Date:** _____

RETURN THIS FORM TO

House of Shalom Therapeutic Services | Toledo, Ohio

Phone: 419.407.6092 Fax: 419.839.2925

Email: levarine@hosts.llc Website: hosts.llc