Hope Springs Counseling General Referral Form

Referral Information

Date of Referral:

Referring Provider/Entity:

Contact Information:

Client Information

Client Name:

Date of Birth:

Phone Number:

Email Address:

Reason for Referral (Check all that apply)

[ ] Anxiety [ ] Depression [ ] Trauma/PTSD [ ] Grief/Loss

[ ] Relationship Issues [ ] Behavioral Concerns [ ] Life Transitions

[ ] Other: _____

Previous Mental Health Treatment

Has the client received counseling before? [ ] Yes [ ] No

If yes, where and when?

Additional Comments/Concerns:

_____

_____

Consent & Authorization

Client/Guardian Consent for Referral: [ ] Yes [ ] No

Signature of Referring Provider/Entity Representative: _____ Date: _____