SANTA ROSA COUNSELING CENTER

REFERRAL FOR COUNSELING SERVICES

PATIENT DEMOGRAPHICS

Last Name | First | MI | Date of Birth | Age

Residence Address | City | State | Zip Code

Telephone: (Home) | (Cell) | (Work)

Insurance Company (if known) | Policy Number

Marital Status:

☐ Single ☐ Married ☐ Separated ☐ Divorced

☐ Remarried ☐ Partnered ☐ Widowed

Gender:

☐ Male ☐ Female

REFERRAL SOURCE AND SUMMARY

Provider/Agency Name | Office Number | Office Fax

REASON FOR REFERRAL

☐ Marriage/Relationship problems
☐ Parenting skills
☐ Anxiety
☐ Depression
☐ ADHD
☐ Anger Management
☐ Employment/School Problems
☐ Grief/Death
☐ PTSD/Trauma
☐ Autism
☐ Foster Care/Adoption
☐ Substance Abuse/Dependency
☐ Abuse _____
☐ Addiction _____
☐ Other _____

REFERRAL SUMMARY

Will a treatment plan and/or summary of progress be required for your office? ☐ Yes ☐ No

☐ The individual/family has been informed to contact your office within two business days to schedule an appointment. The patient was advised to not miss this important appointment and to contact your office at least 24 hours prior should a schedule conflict arise.

☐ It is important to establish coordinated care with psychiatric, primary care, and alternative care providers for continuity of treatment. Please forward the most recent treatment plan, progress note, and any additional information that may be helpful for treatment.

☐ An authorization to release confidential information may be required to coordinate treatment and to disclose protected health information.

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