



## Moving Forward Counseling Center, PLLC

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### Referral Contact Form

#### CLIENT INFORMATION

Name:	Date of Birth	Referral Date:
Gender: <input type="checkbox"/> Male <input type="checkbox"/> Female	School & Grade:	
Contact Numbers:	Message ok? <input type="checkbox"/> Yes <input type="checkbox"/> No	
Address:		

#### PARENT OR LEGAL GUARDIAN INFORMATION:

Name of Parent or Legal Guardian:	Address:
Contact Numbers:	

#### FINANCIAL INFORMATION:

Court Ordered:	Individual Family	Other:
Medicaid <input type="checkbox"/>	Private Insurance <input type="checkbox"/>	Self Pay <input type="checkbox"/> Contract <input type="checkbox"/> Other <input type="checkbox"/>
Insurance ID#	Group#	Phone#

#### PRESENTING PROBLEMS (CHECK ALL THAT APPLY):

<input type="checkbox"/> Hallucinations	<input type="checkbox"/> Sleep disturbance	<input type="checkbox"/> Alcohol
<input type="checkbox"/> Delusions	<input type="checkbox"/> Irritability	<input type="checkbox"/> Marijuana
<input type="checkbox"/> Thought disorder	<input type="checkbox"/> Anger	<input type="checkbox"/> Cocaine
<input type="checkbox"/> Bizarre (psychotic) behavior	<input type="checkbox"/> Grief/Death/Loss	<input type="checkbox"/> Heroin
<input type="checkbox"/> Anxiety / Nervousness	<input type="checkbox"/> Attention deficit/ Hyperactivity	<input type="checkbox"/> Rx Drugs
<input type="checkbox"/> Obsessive / compulsive	<input type="checkbox"/> Eating problems	<input type="checkbox"/> Amphetamines
<input type="checkbox"/> Phobias / fears	<input type="checkbox"/> Runaway	<input type="checkbox"/> Other Drugs
<input type="checkbox"/> Depressed mood	<input type="checkbox"/> Oppositional	<input type="checkbox"/> Suicidal
<input type="checkbox"/> Mood swings	<input type="checkbox"/> Conduct disorder	<input type="checkbox"/> Homicidal
<input type="checkbox"/> Sexual/Physical Abuse	<input type="checkbox"/> Temper Tantrums	<input type="checkbox"/> Other

**Reason for referral for treatment:** In your own words please describe specific behaviors the child/teen is exhibiting.

#### CONTACT/REFERRAL SOURCE:

NAME: \_\_\_\_\_ PHONE: \_\_\_\_\_

AGENCY: \_\_\_\_\_