Client ID #: __________
Office Use Only

Parker Counseling Services, LLC
Jacosta Parker, LCSW-BACS, MSW
parkercounselingservices@gmail.com
Office (504) 383-5880 | Fax 1-504-336-3184

Referral Form

Date: ____________________________

Referral Source (Agency): ____

Name and title of person completing this form: ____

Address: ____

Phone: _____________________________________ **Fax:** _____________________________

Potential Client Name: _______________________________________ **Gender:** ☐ Male ☐ Female ☐ Non-Binary

***Name of parent/ guardian if minor:** ____

Date of Birth: _________________________ **Age:** _______________ **Phone:** _________________________________

Address: ____

Reason for Referral/Presenting Problem: ____

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Current Medications, if any: ____

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Thank you for entrusting Parker Counseling Services with your mental health needs.