Referral Form

Client Information:

- Full Name: _____
- Date of Birth: _____
- Phone Number: _____
- Email Address: _____
- Preferred Contact Method:
  - □ Phone
  - □ Email
  - □ Text
- Emergency Contact Name & Number: _____

Referral Information:

- Referred by (Full Name): _____
- Relationship to Client: _____
- Organization (if applicable): _____
- Phone Number: _____
- Email Address: _____

Reason for Referral

Please provide a brief description of the referral purpose or services needed:

Additional Information

Include any relevant medical or mental health history, concerns, or goals:

Consent to Contact:

By signing below, I give permission for [Therapist's Name or Practice Name] to contact the referred individual regarding the services I offer.

- □ Yes
- □ No

Signature of Referring Party: _____

Date: _____

For Office Use Only:

- Date Received: _____
- Therapist Assigned: _____
- Follow-up Date: _____