THERAPY REFERRAL FORM

Date of Referral (MM-DD-YYYY): _____ /_____ /_____

Is client aware of and agreeable to this referral?

□ Yes □ No

Is this referral urgent?

□ Yes □ No

CLIENT INFORMATION

Name (Last, First, MI): _____

Date of Birth: _____ /_____ /_____ Age: _____ Gender: _____

Parent/guardian (if under 18 years): _____

Address: _____

City: _____ State: _____ Zip Code: _____

Home Phone: _____ May we leave a message? □ Yes □ No

Cell Phone: _____ May we leave a message? □ Yes □ No

E-mail: _____

May we email? □ Yes □ No (Email is not considered to be a confidential medium of communication)

Preferred language(s) of communication: _____

REFERRING PROFESSIONAL

Name (Last, First, MI): _____

Agency/Practice: _____

Address: _____

City: _____ State: _____ Zip Code _____

Phone: _____ Fax: _____

E-mail: _____

REASONS FOR REFERRAL (PRESENTING ISSUES):

_____
_____
_____
_____
_____
_____

ANY RELEVANT MEDICAL OR PSYCHIATRIC HISTORY?

_____
_____
_____
_____
_____
_____

ANY HISTORY OF SUICIDAL IDEATION, AGGRESSIVE BEHAVIOR, AND/OR SELF HARM?

_____
_____
_____
_____
_____
_____

OFFICE USE:

RECEIVED BY: _____ _____
Counsellor Signature: _____

Date: _____