Referral Form

## Demographic Information

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| --- | --- |
| **Name:**  **Parent/Guardian (if applicable):** | **Date of Birth/Age:** |
| **Street Address:** | **Preferred Method of Contact?**  **May we leave a Message?** |
| **City, State, Zip Code:** | **Phone #:** |
| **Gender/Ethnicity:** | **Email Address:** |
| **Primary Care Physician:** | **Psychiatrist (if any):** |
| **Emergency Contact Person/relationship:** | **Emergency Contact Phone:** |
| **Issues of concern (brief description):**  **Services requested/Needed:** | **Referred By (if applicable):** |

Please return completed Referral Form to Healthy Haven Counseling by mail, email, or fax. Forms can also be returned in person or call 888-374-4460 to schedule pick up.

**Mail to:** **Email to:** **Fax to:**

Healthy Haven Counseling [rborders@healthyhavenonline.com](mailto:rborders@healthyhavenonline.com) 575-742-5328

Attn: Renita Borders

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Clovis, NM 88101