QC COUNSELING SERVICES

Client Referral Form

P: (704) 464-8181 | F: (704) 464-8182 | E: hi@qccounseling.com

Referral Information

- ☐ Individual Counseling (Child / Adult)
- ☐ Family Therapy
- ☐ Group Therapy
- ☐ TF-CBT (Ages 3–18)
- ☐ TF-CBT (Ages 3–18)
- ☐ Clinical Assessment
- ☐ Transitional Living Services
- ☐ Intentia™ Therapy
- ☐ Other: _____

Reason for Referral: _____

Client Information

Client Name: _____ ***Date of Birth:*** _____

Current Address / Living Situation: _____

***School & Grade** (if applicable):* _____

Receiving Therapy? ☐ *Yes* ☐ ***No*** *if yes type:* _____

Insurance Information

Insurance Provider: _____ ***Insurance ID #:*** _____

Contact & Availability

Guardian Name: _____ *Phone:* _____ *Email:* _____

Preferred Contact ☐ *Phone* ☐ *Email*

Preferred Meeting: ☐ *Virtual* ☐ *Office* ☐ *Home Visit* _____

Preferred Days/Times: _____

Current Providers *(if applicable)*

Social Worker / Probation Officer: _____

Primary Care Physician / Psychiatrist: _____

Referrer Information

Referrer Name: _____ *Organization:* _____

Phone: _____ *Email:* _____