Client Name: _____

A Better Therapy Connection Inc. 2014 4th street, Suite 6 Sarasota, Florida 34237
Phone: 941.400.7660 Fax: 941.417.3711
Please email: info@abettertherapyconnection.com Website: abettertherapyconnection.com

REFERRAL FOR OUTPATIENT COUNSELING SERVICES

❑ **Mental Health Assessment** ❑ **Therapy Services**

Client Information: Name: _____ SS #: _____ - _____ - _____

DOB: _____ /_____ /_____ Age: _____ ❒Male or ❒Female Language Spoken: _____

Insurance Provider Name#: _____ Insurance Provider Number: _____

***Full Address w/City & Zip:** _____

Name: _____ Phone #: _____

Relationship to client: _____ Legal Guardian: ❒Yes or ❒No

If no, who is legal guardian: _____ Relationship: _____

Client Referral Source:
Contact Person: _____ **Email:** _____
Address: _____
_____
Phone #: _____ **Fax #:** _____

***REASON for REFERRAL:** _____
_____
_____
_____

Client Diagnostic Information: ❒ Check if Client Diagnostic Information is Unknown
Diagnosis: Axis I: _____ DSM/ICD10_____
Axis II: _____ DSM/ICD10_____
*** **Medications (name, dosage, frequency):** _____
_____

Current Psychiatric Provider: Name: _____ Phone #: _____
Address: _____

_____ _____
Signature of Person Completing Form Date

FOR OFFICE USE ONLY ❒ Not appropriate for services Date Referral received: _____

Date Auth. Received: _____ Date Assigned: _____ Date of Assessment: _____

Call #1-Date: _____ Call #2-Date: _____ Call #3-Date: _____ Call #4-Date: _____
Outcomes/ _____ / _____ / _____ / _____
Notes:_____
_____
_____
_____