View Point Clinical Therapy Services, LCSW, PLLC

Referral Form

Date of Referral: _____

Referral Source

Referral Source Name: _____

Referral Source Phone Number: _____

Referral Source Email: _____

Relationship to Client being Referred: _____

Client Information

Client Name: _____

Client Contact information (Phone/email): _____

Client Address: _____

Client DOB: _____

Insurance Information (Insurance Carrier/Member ID Number): _____

_____

Reason for seeking Therapy

What is the primary reason for seeking therapy? _____

_____

Have you previously suffered from this complaint? _____

If Yes, enter previous therapist(s) seen for complaint, describe treatment:

_____

Previous diagnoses/mental health treatment:

_____

Current Symptoms

(check all that apply)

- [ ] Anxiety
- [ ] Appetite Issues
- [ ] Avoidance
- [ ] Crying Spells
- [ ] Depression
- [ ] Excessive Energy
- [ ] Fatigue
- [ ] Guilt
- [ ] Hallucinations
- [ ] Impulsivity
- [ ] Irritability
- [ ] Libido Changes
- [ ] Loss of Interest
- [ ] Panic Attacks
- [ ] Racing Thoughts
- [ ] Risky Activity
- [ ] Sleep Changes
- [ ] Suspiciousness

Medical Conditions

Current medical conditions/symptoms? _____

Any current Medications? _____

Employment

Work: _____

Legal/Criminal History _____

Any pending legal charges or legal involvement? _____

_____

Are you currently on Probation/Parole/Family Treatment Court/any legal mandates for treatment?

- [ ] Yes
- [ ] No

Name of Entity/Officer mandating Treatment: _____

What type of Treatment is being mandated? (DV group, Assessment only, SO Group, Ind Therapy):

_____

Reason for Mandated Treatment::

_____

Substance/Alcohol Use

Have you ever been treated for drug/alcohol abuse? If yes, when? What type? For what substance?:

_____

Are you currently in substance use treatment?

_____

- [ ] Yes
- [ ] No

Additional

Misc. Information Beneficial for Therapist to Know: _____

_____

Modality of therapy being requested (virtual/telephonic; in-office; in-home)

_____

Availability for Therapy Sessions:

_____

Fax completed form to (315) 270-1910 or
Email: referrals@vptherapyservices.com

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