DATE OF 1st CALL:

CTG Counseling and Addictions Services
1871 Acushnet Ave.
New Bedford, Ma
02746

Referral Form for Mental Health Services

Client Information

Name:	Date of Birth:	Race/Ethnicity:
Gender: ❐ Male ❐ Female ❐ Couple	School & Grade:	
Services Requested: ❐ Office-Based Outpatient	❐ School Based (if therapist is available)	
Service Location: ❐ New Bedford Office	❐ Home (If appropriate)	❐ School (if appropriate)
CONTACT NUMBERS:		Message ok? ❐ Yes ❐ No
ADDRESS:		

Parent or Legal Guardian Information:

Name of Parent or Legal Guardian:	Address:
Contact Numbers:	Type of setting: ❐ Home ❐ Group Home ❐ Foster Home ❐ Psychiatric hospital ❐ Other

Payment Information:

Type of Insurance ❐ BMC ❐ MBHP/Steward ❐ BCBS Other❐ If no insurance, household income:	
Insurance ID#	Phone #

Referral Source Information: Complete this section so we can contact you after the referral is made.

Name	Mailing Address
Phone#	Email address
How did you hear about CTG Counseling?	

Child/Adult Mental Health Information:

Current medication & dosage	Current DSM-IV Diagnosis
	Axis I
	Axis II
	Axis III
	Axis IV
	Axis V
Prescribing Physician name & Phone	

Current Mental Health Symptoms:	Unknown	Not Present	Mild	Moderate	Severe
Hallucinations (describe)					
Delusions					
Thought disorder					
Bizarre (psychotic) behavior (describe below)					
Anxiety / Nervousness					
Obsessive / compulsive					
Phobias / fears					
Depressed mood					
Mood swings					
Sleep disturbance					
Irritability					
Anger / temper tantrums					
Hyperactivity					
Attention deficit					
Eating problems					
Elimination problems					
Oppositional / defiant to those in authority					
Antisocial / delinquent behavior / conduct disorder					
Over sexualized behavior					
Somatic complaints with no known medical cause					
Attachment disorder (explain below)					
Other (explain)					

Reason for referral for treatment: In your own words, describe the child/adult in need for mental health services. Please describe specific behaviors the child/adult is exhibiting.

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Additional Comments ____

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Been in counseling before?: ____

Availability:____

Counselor Preferences:____