**Clarity Counseling Services**

**Theresa M. Lampack, LMHC**

**200 Washington St., Suite 205**

**Watertown, NY 13601**

**Phone: 315-860-1781 Fax: 315-800-6487**

**Referral Form**

# Client Information

Full Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ **\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_** Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

 *Last First M.I.*

Address:

 *Street Address Apartment/Unit #*

 *City State ZIP Code*

Phone: Insurance

 Reason for Referral:

# Referral Source

Full Name: **\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

 *Last First*

Address:

 *Street Address Apartment/Unit #*

 *City State ZIP Code*

Phone:

# Return Form

**Please fax completed form to: Theresa Lampack, LMHC, 315-800-6487**