KELLIN FOUNDATION

Date Received: _____

Referral Form

(Please Print)

Date:	**Referral Source:** (person completing form)
	Referring Agency:
	Referral Contact Information: (email, telephone)

CLIENT INFORMATION

Name: (First, MI, Last)		**Preferred Name:**
DOB:	**Gender:**	**Race:**
Telephone Number(s):		**Preferred Language:**

May we contact you and leave a message at this number(s): **YES** **NO**

Address:

May we mail correspondence at this address: **YES** **NO**

Insurance: **YES** **NO** If yes, list provider and ID#:

PARENT OR LEGAL GUARDIAN'S INFORMATION

Parent(s) or Legal Guardian(s):

Relation to Client:

Telephone Number(s):

Address: (if different from referred client)

SERVICE INFORMATION

Type of Services Requested:

- ☐ Outpatient Therapy
- ☐ Couple/Family Therapy
- ☐ Patient Navigation/Advocacy
- ☐ Peer Support
- ☐ Groups
- ☐ Psychological Evaluation

Is client currently receiving Mental Health or Substance Abuse services? **YES** **NO**

If yes, list services:

Primary Behavioral Health Diagnosis (if any):

Reason for Referral: (symptoms, struggles, past/recent trauma)

Please attach most recent evaluation, if any

_____ _____

Signature of Person Completing the Form Date

Please submit your referral form to: referral@kellinfoundation.org or fax it to 336-429-5600