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:** (optional)
Telephone Number(s):		
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