Referral Form for Outpatient Counseling Services

What type of service are you seeking?

☐Mental Health Therapy ☐Substance Use Therapy
☐Mental Health and Substance Use Therapy

General Information

Name:_____Preferred Name: _____DOB:_____

Contact Number: (primary)_____(alternate)_____

Email: _____

Address:_____

Gender: ☐M ☐F ☐Trans M/F ☐Trans F/M Veteran: ☐Y ☐N
Pronouns: ☐She/Her ☐He/Him ☐They/Them

For children only

School:_____Grade: _____

Parent/Legal Guardian Information

Name:_____Contact Number:_____

Address:_____

Referral Source Information

Name:_____Relationship to Client:_____

Contact Number:_____Email: _____

Client or Guardian is aware of this referral and open to contact from clinic staff? ☐Y☐N

Payment Information (Check One)

☐Private Insurance ☐Medicaid ☐No Insurance

Reason for Seeking Services (Check all that apply)

☐Alcohol/Drug Use ☐Depression ☐Anxiety
☐Anger ☐Mood Swings ☐Grief
☐Family Problems ☐Peer Problems ☐Unusual Fears/Phobias
☐Physical Abuse ☐Emotional Abuse ☐Sexual Abuse
☐Domestic Violence ☐Traumatic Event ☐Nightmares
☐Court Ordered Assessment

Relevant History

Primary Care Physician:_____Clinic Name:_____

Current Mental Health Diagnosis:_____

List all current medications:

Who prescribes these medications?

Physician:_____Clinic Name:_____

History of Psychiatric Hospitalization: (list approximate date and facility)

History of suicidal thoughts or self-harm: (please describe and list approximate date of last occurrence)

History of Past Mental Health or Substance Use Treatment: (list approximate date and provider)

Social Factors:

☐Homeless ☐Unemployed ☐Health Issues -weight loss surgery done

☐Other significant stressors in your life:_____

Priority Service Populations:

☐Currently Pregnant ☐Parenting ☐Current IV Drug Use

Anything else you think is important for us to know: