



Winder, GA, 30680 • Garden City ID 83714 • Beaverton, OR 97008 • Phone 770-291-0419 • Fax 240-348-8500

REFERRAL FORM

<b>REFERRAL SOURCE</b> (if other than self-referral or caregiver referral)			Date:
Name:	Agency	Title:	
Phone #:	Fax #:	E-mail:	

<b>CLIENT INFORMATION</b> (please confirm correct name spelling and DOB with client and/or guardian)			
First Name:	Last Name:	DOB:	
Sex Assigned at Birth Please select	Gender Identity Please select	Sexual Orientation Please select	Pronouns Please select
Other?	Other?	Other?	Other?
Social Security #:	Insurance:	Insurance ID #:	
Street Address:			Apartment/Unit #:
City:		State:	Zip Code:
Home/Cell Phone:	Work Phone:	Email:	
Name of School:			

<b>CAREGIVER #1</b> (if client is a minor)		Relationship to Minor:	Preferred Language:
First Name:	Last Name:	DOB:	
Street Address:			Apartment/Unit #:
City:		State:	Zip Code:
Home/Cell Phone:	Work Phone:	Email:	

<b>CAREGIVER #2</b>		Relationship to Minor:	Preferred Language:
First Name:	Last Name:	DOB:	
Street Address:			Apartment/Unit #:
City:		State:	Zip Code:
Home/Cell Phone:	Work Phone:	Email:	

Do the caregivers have full custodial rights to make medical and educational decisions for this child?	Yes	No
Is there another parent or caregiver with joint custody we should inform about treatment?	Yes	No
Does the client have thoughts of self-harm or of harming others?	Yes	No
Does the client have an urgent or critical medical condition?	Yes	No
Does the client have a safety threat?	Yes	No

<b>REASON FOR REFERRAL?</b>				
Requested Services:	Counseling	Medication Management	Diagnostic/Assessment	Group
	Crisis/IFI Service	Substance Use	EMDR	Other:
A brief summary will require assignment to a clinician:				

<b>HOW DID YOU HEAR ABOUT US?</b>	
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**\*\*Please note: medication management (psychiatric) services are only available for clients receiving counseling services. We are unable to accept referrals for medication management only.**