**Referral for Services**

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| **Client’s Name (*First, Middle Initial, Last Name*):** | | | **Date:** |
| **Date of Birth (DOB):**  **Address:** | | | **Phone# *(with area code)*:**  **Email:** |
| **School/Employer (if applicable): Sex: x Male**  **Transgender**  **Female Non-Binary** | | **Grade: Race: AA** | |
| **Medical Assistance#:** | **Number of Children (if applicable):** | | |
| **Social Security#:** | **Returning from an Institution?** **YES** **NO** | | |
| **Private insurance Information:** | | | |
| **Name & Address of Parent, Guardian or Care Taker. (*Required for Minors*)** | | | |
| **Name & Relationship:** | | | |
| **Address:** | | | |
| **Phone#** | | | |
| **REFERRAL SUMMARY** | | | |
| 1. **Reason for Referral:** | | | |
| **2. Behavioral Diagnosis and Description (*include ICD-10 code*):** | | | |
| **3. Presenting Issues: anxious, depressed** | | | |

***Applicable*):**

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| **REFERRAL SIGNATURE:** | |
| **Referring Name and Title: self**  \\\ | |
| **Referring Organization, Address and Phone:** | |
| **Referring Signature:** | **Date:** |
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