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REFERRAL FORM

Relationship to person being referred: _____
 Date _____ Last Name _____ First Name _____
 Address _____ City _____
 State _____ Zip _____ Phone _____ Email _____

Information of Person Being Referred:

Date _____ Last Name _____ First Name _____
 Address _____
 City _____ State _____ Zip _____
 Sex (M/F) _____ Birth Date _____ SS# _____
 Parent[s] or Guardian[s] Name [first & last]: _____

May I contact you by email for scheduling purposes? _____

Email Address: _____

Local Phone _____	Can I call you here? _____	Can I leave a message? _____
Cell Phone _____	Can I call you here? _____	Can I leave a message? _____

Please check any current or past issues that still affect you:

- | | |
|--|---|
| <input type="checkbox"/> Eating Disorders | <input type="checkbox"/> Pregnancy Issues |
| <input type="checkbox"/> Academic Issues | <input type="checkbox"/> Spiritual Concerns |
| <input type="checkbox"/> Childhood Abuse (i.e. physical, sexual, emotional) | <input type="checkbox"/> Depression |
| <input type="checkbox"/> Stress/Anxiety | <input type="checkbox"/> Pornography |
| <input type="checkbox"/> Phobias (type: _____) | <input type="checkbox"/> Sexual Identity Issues |
| <input type="checkbox"/> Alcohol/Other Drug Use | <input type="checkbox"/> Relationship Concerns |
| <input type="checkbox"/> Sexual Assault/Rape | <input type="checkbox"/> family |
| <input type="checkbox"/> _____ recently (when: _____) | <input type="checkbox"/> friend |
| <input type="checkbox"/> _____ in the past | <input type="checkbox"/> parent |
| <input type="checkbox"/> Death of someone close | <input type="checkbox"/> significant other |
| <input type="checkbox"/> _____ recently (when: _____) | <input type="checkbox"/> roommate |
| <input type="checkbox"/> _____ in the past | <input type="checkbox"/> other: _____ |
| <input type="checkbox"/> Family Issues (i.e. divorce, alcoholism, domestic violence) | <input type="checkbox"/> Suicidal Thoughts |
| <input type="checkbox"/> Other: _____ | |

Please check any previous interventions:

- | | |
|--|--|
| <input type="checkbox"/> Individual Counseling | <input type="checkbox"/> School observations/testing |
| <input type="checkbox"/> Group Counseling | <input type="checkbox"/> Tutoring |
| <input type="checkbox"/> Medication | <input type="checkbox"/> Inpatient Treatment |
| <input type="checkbox"/> Psychological Assessments | <input type="checkbox"/> Other _____ |

Additional information/explanation [optional]: _____

