**CLIENT REFERRAL FORM**

**DATE:** Click or tap here to enter text.

**REFERRAL SOURCE (Agency/Person):** Click or tap here to enter text.

**Address:** Click or tap here to enter text. **City:** Click or tap here to enter text. **State:** Click or tap here to enter text. **Zip:** Click or tap here to enter text. **Phone:** Click or tap here to enter text. **Fax:** Click or tap here to enter text. **Email:** Click or tap here to enter text.

**Prospective Client Information:**

**Name:** Click or tap here to enter text. **DOB:** Click or tap here to enter text.

**Address:** Click or tap here to enter text. **City:** Click or tap here to enter text. **State:** Click or tap here to enter text. **Zip:** Click or tap here to enter text. **Phone:** Click or tap here to enter text. **Email:** Click or tap here to enter text.

***If the client is a minor, please complete the following:***

**Caregiver 1: (Parent/Legal Guardian)**

**Name:** Click or tap here to enter text. **Phone:** Click or tap here to enter text. **Email:** Click or tap here to enter text.

**Caregiver 2 (Parent/Legal Guardian)**

**Name:** Click or tap here to enter text. **Phone:** Click or tap here to enter text. **Email:** Click or tap here to enter text.

**REFERRED FOR:**

**Individual counseling**

**Play therapy**

**Family counseling**

**Other, please describe:** Click or tap here to enter text.

**Brief Description of Presenting Concern:** Click or tap here to enter text.

**BILLING INFORMATION:**

**Primary Insurance** Click or tap here to enter text. **Policy holder name:** Click or tap here to enter text. **Policy #:** Click or tap here to enter text. **Group #:** Click or tap here to enter text. **Insurance Phone:** Click or tap here to enter text. **Medicaid #:** Click or tap here to enter text.