

## REFERRAL FOR SERVICES

Referral Source Information	
Referral Source Name	
Referral Source Contact Information	

Client Information	
First & Last Name	
Date of Birth	
Address	
Phone Number	
Email Address	
Parent/Guardian (if applicable)	
Insurance Type	
Insurance Number	

### Services Requested

- Individual Therapy     
  Family Therapy     
  EMDR Therapy     
  Play Therapy  
 Mentoring Services     
  Other: \_\_\_\_\_

### Therapy Preferences

- In Person     
  Telehealth / Virtual     
  Morning(s)     
  Afternoon(s)  
 Evening(s)     
  Weekend(s)     
  Other: \_\_\_\_\_

### Reported Symptoms

- Anxiety     
  Depression     
  Self-Esteem     
  Trauma  
 ADHD     
  Suicidal/Homicidal Ideation     
  Anger / Aggression     
  Tantrums / Outbursts  
 Social Isolation / Changes     
  Other: \_\_\_\_\_

### Additional Information (as applicable)