COUNSELING REFERRAL FORM
Fax to: 218 461-3873

The Therapist
COUNSELING & LIFE COACHING

Date of Referral: _____ /_____ /_____ (DD-MM-YYYY)

Is client aware of and agreeable to this referral? □ Yes □ No

Is this referral urgent? □ Yes □ No

CLIENT INFORMATION

Name: _____

Birth Date: _____ /_____ /_____ Age: _____ Gender: _____

Parent/guardian (if under 18 years): _____

Address: _____

City: _____ State: _____ Zip: _____

Home Phone: _____ May we leave a message? □ Yes □ No

Cell Phone: _____ May we leave a message? □ Yes □ No

REFERRING PERSON/AGENCY

Agency: _____

Name: _____ Title:_____

Address: _____

City: _____ State: _____ Zip: _____

Phone: _____ E-mail:_____

REASONS FOR REFERRAL (PRESENTING PROBLEMS):
Symptoms/behaviors

_____
_____
_____
_____

PRIMARY INSURANCE: ☐ Medicare ☐ Medicaid ☐ Private Pay ☐ Private Insurance ☐ Other:_____

Insurance Provider:_____ Group Number:_____ ID or Policy:_____

OFFICE USE: RECEIVED BY_____

Actions Taken:_____

_____ _____
Counselor Signature **Date**