IMPACTING tomorrow HEALTH CENTER

"Improving The Quality Of Lives"

Therapeutic Counseling Referral Form

Demographic Information

Client Name:	DOB:	Age:
Address:	City:	Zip:

Contact Number:	SSN:	Medical Assistance #:
Gender:	Ethnicity:	Marital Status:
Highest Completed Grade Level:	Employment Status:	Legal Status (# of arrests in past 30 days):
Legal Guardian Name (if applicable):	Relationship:	Email Address:

Referral Source

Name & Agency:	Contact Number:	Email Address:

Reason For Referral (check all that apply):

☐ Behavior/Conduct ☐ Emotional Mental Illness ☐ Employment Instability ☐ Legal/Probation/Court Mandated ☐ Social/Interpersonal Challenges ☐ At Risk ☐ Substance Use/Abuse ☐ Educational Instability

Services Requested (check all that apply):

☐ Individual Counseling ☐ Family Counseling ☐ Group Supports Counseling ☐ Grief and Loss Counseling
☐ Recovery and Relapse Understanding ☐ Anger Management ☐ Trauma Recovery
☐ Sexual Abuse Counseling ☐ Behavior Modification Therapy ☐ Social/Interpersonal Skills Group Counseling
☐ Promotion of Wellness & Self-Management ☐ Survivor Counseling ☐ Arts Therapy ☐ Expressive Therapy
☐ Occupational Therapy ☐ Physical Therapy ☐ Play Therapy

Symptoms and Behaviors of Risk: (check all that apply)

☐ Anxiety/Panic ☐ Adjustment Challenges ☐ Depressed Mood ☐ Psychotic Features
☐ Suicidal Ideations/ Attempts ☐ Homicidal Ideations/ Attempts ☐ Isolative Behaviors ☐ Hyperactive
☐ Manic Mood ☐ Impulsivity ☐ Physical Aggression ☐ Verbal Misconduct ☐ Unlawful Activity
☐ Self-Care Deficit ☐ Social Withdrawal ☐ Obsessions/Compulsions ☐ Physical Pain/Discomfort
☐ Changes In Sleeping Pattern ☐ Changes In Appetite

Please Discuss Presenting Problem:

Does client have a history of receiving mental health services? ☐Yes ☐No

Check all traumatic events that you have experienced:

☐ Witness or victim of domestic violence	☐Victim of rape or sexual violation (abuse)
☐Natural Disaster **(hurricane, earthquake, flood, tornado, windstorm, wildfire, tsunamis, avalanche)**	**Indicate what type:**

Please Indicate Current Diagnosis (If Applicable and Known):

Diagnosis Code (DSM-V):	Description:
Diagnosis Given By:	Date:

Please List ALL Medications:

Do you have access to transportation? ☐Yes ☐ No

If no, how can we accommodate you with transportation to receive counseling?

☐ Prefer services in home ☐ Provide transportation service to Site

Impacting Tomorrow Health Center Administrative Use Only

Check off once completed	Date Completed
☐ Verify Eligibility	
☐ Contact referral source and client	
☐ Scheduled Orientation and Intake Meeting	**Date of meeting:**

_____ _____

Administrative Coordinator Printed Name Signature & Date