IMPACTING TOMORROW HEALTH CENTER, Co.

"Improving The Quality Of Lives"

Therapeutic Counseling Referral Form

Client Name: **DOB:** **Age:** **Gender:** **Ethnicity:**

Address: **City:** **State:** **Zip:**

Contact #1: **Contact #2:**

SSN: **Medical Assistance#**

Primary Language:

Legal Guardian Name (if applicable): **Relationship:**

Referral Prepared By:

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:

_____
_____
_____
_____

Do you 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 **i.e. hurricane, earthquake, flood, tornado, windstorm, wildfire, tsunamis, avalanche** **Indicate what type:**

Please Indicate Current Diagnosis (If Applicable and Known) **Given By:**

Axis I:

Axis II:

Axis III:

Axis IV:

Axis V: GAF

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

Is there anything else that you would like to tell us about yourself?

_____

_____

_____

_____

_____

_____

_____

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