REFERRAL FOR COUNSELING SERVICES

Date_____

Client's First Name_____ Last Name_____ MI_____

Name of Parent/Guardian if applicable_____

Address_____ City_____ State_____ Zip_____

Telephone (Home)_____ (Cell)_____

E-mail: _____

Birth date_____/_____/_____ Gender __F __M

Insurance Plan: _____ Policy #: _____

Reason for Referral:

☐ Anxiety	☐ Depression	☐ Inattentiveness	☐ Impulse Control
☐ Panic Attacks	☐ Self Mutilation	☐ Social Skills	☐ Anger Management
☐ Noncompliance	☐ PTSD Symptoms	☐ OCD Symptoms	☐ Phobia _____
☐ Eating Disorder	☐ Legal	☐ Sexual Issues	☐ Separation /Loss
☐ Self-esteem	☐ Substance Abuse	☐ Family conflict	☐ Hallucinations
☐ Sleep Issues	☐ Nervousness/Tension	☐ Relationship Issues	☐ _____

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Has the client been made aware of the referral to BAYS? _____

Is a Release of Information form attached so that we may inform you of the outcome of the referral? _____

Referred by:

_____ _____

Signature Date

_____ _____

Printed Name and Title Agency Name

Phone: _____ Fax: _____

E-mail: _____

Please e-mail form to bayscommunitycare@baysflorida.org