

Therapist Name:

Counseling Referral Form

Client Name:

Today's Date:

Date of referral:	
Referral to name:	Referral to practice:
Is the client aware of and in agreement of this referral? <input type="checkbox"/> Yes <input type="checkbox"/> No	
Is this referral urgent? <input type="checkbox"/> Yes <input type="checkbox"/> No	

REFERRING INFORMATION

First Name:	Last Name:		
Practice Name:			
Address:	City:	State:	Zip:
Phone #:			
Email address:			

CLIENT INFORMATION

First Name:	Last Name:		
Date of Birth:	Age:	Gender:	
Guardian name (if under 18):			
Address:	City:	State:	Zip:
Phone #:	Can we leave a message?	<input type="checkbox"/> Yes <input type="checkbox"/> No	
Email address:	Can we email?	<input type="checkbox"/> Yes <input type="checkbox"/> No	
Reason for referring?			
Additional notes:			