111 Library Hill Lane, Suite A,
Lexington, SC, 29072
Ph: 803-851-4049
Fx: 803-785-4948
www.ChoicesSC.com

Referral

Date: _____

Referring Agency: _____

Contact Name: _____

Phone Numbers: _____

Email: _____

Will this agency be paying for services? _____ Yes _____ No

Client Name: _____

Date of Birth: _____

If child, Parent/Legal Guardian: _____

Phone Numbers: _____

Email Address: _____

Address: _____

Court Order(s) and/or Agency Requests:

Group Services:	**Counseling:**
___Abuse Clarification	___Adult
___Parenting & Protection Clarification Combo	___Child
___Intimate Partner Violence: 12-week psychoeducation	___Family Reunification
___Anger Management: 6-week psychoeducation course	___Supervised Visitation
Assessments:	
___ Psychological/Psychosocial	
___CAP (Child Abuse Potential Inventory)	
___CAT-A (Clinical Assessment of **Adult** Attention Deficit/ ADHD)	

Treatment Services Court Ordered? ___No ___Yes, by: ___Criminal ___DSS
No Contact Order: ___No ___Yes
Order of Protection: ___No ___Yes

If you answered yes to any of the above, please attach the orders to this document.

Forms may be faxed or securely emailed to referrals@choicessc.com

Signature:_____