Inspiring Horizons
Counseling & Wellness, LLC

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INSPIRING HORIZONS REFERRAL FORM

REFERRAL SOURCE:_____REFERRAL SOURCE PHONE:_____

REFERRAL SOURCE FAX:_____

CLIENT INFORMATION

CLIENT NAME: _____ DOB:_____AGE:_____

PH:_____ CELL:_____

CONTACT NAME OR GUARDIAN:_____ RELATIONSHIP:_____

ADDRESS:_____

PRIMARY INSURANCE:_____ SECONDARY INSURANCE:_____

REASON FOR REFERRAL (PRESENTING SYMPTOMS/PROBLEMS/DX HISTORY & CURRENT DIAGNOSTIC INFORMATION):_____

_____

_____

_____

PLEASE CIRCLE AREAS OF CONCERN OR LIST DX HISTORY:

Anxiety Depression Truancy ODD Substance Use/Abuse Alcoholism Abuse/Neglect ADHD Behavioral Problems Aggressive Behaviors Youth Service APS Case CPS Case Bipolar Grief Disorder Eating Disorder Trauma Personality Disorder Adjustment Disorder/difficulties

Autism Spectrum Disorder Court-Ordered Mental Health Treatment Insurance Private Pay

Other:_____

_____

_____

_____

Office Use Only

INTAKE Scheduled:_____ Client Refused Services: _____
Follow Up 1:_____
Follow Up 2:_____
Follow Up 3:_____