Damron Counseling

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Date of referral: _____

Client Name: _____ DOB: _____ Gender: _____

Phone Number: _____ Leave message? YES NO

Address: _____

Email Address: _____

For minors, legal guardian(s) name/relationship:

_____

School: _____ County: _____ Grade: _____

Referred by: _____

Referral Address: _____

Referral Phone: _____ FAX: _____

Email: _____

□ Do you wish to be updated on the status of this referral? YES NO

□ Do you have any specific requests regarding this referral? YES NO

□ If yes, explain:

_____

Reason for referral:

_____

Is the client reporting that they are a danger to themselves or others? YES NO

□ If yes, explain:

_____

Substance abuse issues/concerns reported? YES NO

□ If yes, explain:

_____

Has the client received mental health services in the past? YES NO

□ If yes, when and where: _____

Previous mental health diagnosis: _____