New Referral/Client Information

Fax Completed Form to: (317) 245-2367

Choices in Counseling

Directions: This form is intended to be used by physicians, nurse practitioners, school guidance counselors, social workers, and/or other potential referral sources wishing to make a direct referral to Choices in Counseling. All information on this referral form is considered confidential and will become a part of the client's permanent record. Please complete the form as accurately and fully as possible as this will help match clients with an appropriate counselor. (Additional copies of this form can be downloaded from our web site.)

Date of Referral: _____ Return Fax Number: _____

Referral Agency Name: _____ Phone: _____

Follow-Up Contact Name: _____ Ph/Fax: _____

Client Name: _____ Age: _____ DOB: _____

Address: _____ Phone_____

_____ Phone_____

Guardian (If under age 18): _____

Guardian Relationship: **Mother Father Grandparent Other:** _____

Best time to contact client to schedule an appointment? **Morning Afternoon Evening Any**

Presenting Concern: _____

_____

_____

Does this client have primary insurance? **Yes No** If yes, type: _____

Does this client have secondary insurance? **Yes No** If yes, type: _____

Additional Comments: _____

_____

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www.ChoicesInCounseling.com