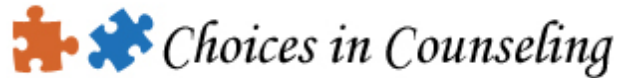


New Referral/Client Information



Fax Completed Form to: (317) 245-2367

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: _____