ANDERSON
COUNSELING SERVICES

# REFERRAL FORM

**PLEASE COMPLETE ENTIRE FORM—PAGE 1 OF 2**

**Referral Source:**

Name/Title: _____ Date: _____

Agency: _____ City/Town: _____

E-mail: _____ Contact Number: _____

Reason for referral: _____

_____

_____

Funding Source: ☐ FAPT/CPMT ☐ Medicaid

Medicaid #: _____ Medicaid Provider: _____

**Student Data:**

Full Name of Client: _____ SSN#: _____

Street Address: _____ Apt. #: _____

City: _____ State: _____ Zip: _____

D.O.B. _____ Age: _____ Gender: _____ School Attending: _____

Has the client ever been hospitalized for psychiatric care? ☐ Yes ☐ No

If yes, was the hospitalization within the past 30 days? ☐ Yes ☐ No

**(Child services only)**

Parents/Guardians Name(s): _____

Relationship to student: _____

Street Address (or "same as student"): _____ Apt. #: _____

City: _____ State: _____ Zip: _____

Phone: Home: _____ Work: _____ Cell: _____

Child is at risk of removal from: □ Home □ School □ Community

Explain why child is at risk of removal: _____

_____

_____Signature: _____

**(TDT Services only)**

I (parent/guardian) _____of (child) _____ hereby authorize (school) _____ to exchange all information as necessary for the purpose of assessment, evaluation, and treatment with Anderson Counseling Services.

Parent/Guardian Signature: _____ Date: _____

(For in-school referrals verbal permission is allowed) ☐Verbal permission granted on: _____ Initial: _____

**List of current service providers involved with the child: List Name, Title and Phone number below:**
***(ie; Psychiatrist, Therapist, Social worker, Probation officer, Foster parent)***

| NAME | TITLE | TELEPHONE # |
|---|---|---|
| | | |
| | | |
| | | |
| | | |
| | | |
| | | |

Please call our main office with any questions pertaining to this form or the referral process. 434-239-2004 ext. 105

## --------For Office Use Only--------

Referral received date: _____

Referral appropriate? ☐Yes ☐No

If no, state reason:

_____

Referral given to: ☐ Therapeutic Day Treatment ☐ Intensive In Home ☐ Mental Health Skill Building

Admissions Coordinator Signature: _____ Date: _____

**Notes:**

_____

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