



Referral Form

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Raleigh, NC 27615
(919) 637-4089 office #; (919) 322-8236 crisis #
Fax: 1-888-462-2058
Itlabcounseling@gmail.com
<https://www.etcounseling.com/>

Thank you for your referral. Our agency will contact you to confirm that the referral has been received. We will contact the client to schedule an appointment.

.....
Referral Date: _____

Self-Referral: Yes No EAP Referral: Yes No CPS/Court Ordered: Yes No

Referral Source (Name and Agency) _____

Referral Contact Phone#: _____ Referral Fax: _____

Relationship to Client, *if not a self-referral*: _____

Referral Address: _____

.....
Client Name: _____ Preferred Name: _____

Ethnicity: _____ Gender: _____ Date of Birth: _____

SS#: _____ or Last Digits of SS#: _____

Address: _____ City: _____ Zip: _____

School Name: _____ Grade: _____ Year-a-round: Traditional:

Contact #: _____ Home# _____ Cell# _____ Work# _____ Preferred Contact: _____

Contact #: _____ Home# _____ Cell# _____ Work# _____ Preferred Contact: _____

Contact #: _____ Home# _____ Cell# _____ Work# _____ Preferred Contact: _____

Email Address: _____ Personal Work Preferred Contact: _____

Self-Pay/ Sliding Fee Scale Request: Yes No

Type of Insurance: (Please attach copy of *Insurance Card*, front and back of card)

Blue Cross Blue Shield Aetna Cigna Medicaid Tricare Humana

Other: _____

Policy #: _____ Group #: _____

Primary Policyholder: Self Mother Father Spouse

If this is not a self-referral, please type the person's name and contact information of the policyholder:

First Name: _____ Middle Name: _____ Last Name: _____

Gender: _____ Date of Birth: _____ Employment: _____

Phone#: _____ Address: _____

City: _____ Zip: _____

.....



Referral Services Requested

Individual Therapy Family Therapy Couple Therapy Group Therapy
 Immigration Assessment (Schedule Hearing Date: _____)

.....
Location of Services Request:

In Office Via Computer (using Telehealth Service, reserved for Self-Pay Clients or with prior approval through Insurance)
 In Community (i.e. Home Residence)

.....
Parent Information

.....
Mother's Name: _____ Preferred Contact for Emergency: Yes No

Legal Guardian: Sole Custody: Yes No

Mother aware therapy is being requested

Not Involved in Child's Life Mother is deceased

Restraining Order in Place: to protect Mother Father

Home Address: _____

Contact #: _____ Home# Cell# Work# Preferred Contact: _____

Contact #: _____ Home# Cell# Work# Preferred Contact: _____

Contact #: _____ Home# Cell# Work# Preferred Contact: _____

Email Address: _____ Personal Work Preferred Contact: _____

Email Address: _____ Personal Work Preferred Contact: _____

.....
Father's Name: _____ Preferred Contact for Emergency: Yes No

Legal Guardian: Sole Custody: Yes No

Father aware therapy is being requested

Not Involved in Child's Life Father is deceased

Restraining Order in Place: to protect Mother Father

Home Address: _____

Contact #: _____ Home# Cell# Work# Preferred Contact: _____

Contact #: _____ Home# Cell# Work# Preferred Contact: _____

Contact #: _____ Home# Cell# Work# Preferred Contact: _____

Email Address: _____ Personal Work Preferred Contact: _____

Email Address: _____ Personal Work Preferred Contact: _____



Alternative Contact for Emergency:

First Contact: _____ Relationship to Client: _____

Contact #: _____ Home# ____ Cell# ____ Work# ____ Preferred Contact: _____

Email Address: _____ Personal ____ Work ____ Preferred Contact: ____

Home Address: _____

.....
Legal Guardian, if not mother or father of child:

Full Name: _____ Relationship to Client: _____

Contact #: _____ Home# ____ Cell# ____ Work# ____ Preferred Contact: _____

Email Address: _____ Personal ____ Work ____ Preferred Contact: ____

Home Address: _____

.....
Reasons for referral ...

___ Depression

___ Anxiety

___ ADHD

___ Anger Problems

___ Grief/ Loss

___ Relationship Issues

___ Social Isolation/ Shyness

___ Disruptive behaviors: ____ Home ____ School

___ Life Transition Challenges

___ Custody Stress with: ____ Parents

_____ Child's Parent (Parent: ____ Mother ____ Father ____ Other: _____)

___ Blending Family Issues

___ Motivation

___ Occupational Distress

___ Trauma: ____ Domestic Violence ____ Abuse (____ Physical ____ Emotional ____ Sexual)

___ Currently Happening ____ Experience in the Past



Additional Needs (*This will be included as a focus in therapy*):

___ Problems with Family: ___ divorce ___ death ___ sexual abuse ___ discord with siblings

___ Problems with Social relationships outside of the family: ___ living alone ___ friend's death

___ Educational Problems: ___ illiteracy ___ academic ___ peer problems

___ Occupational Problems: ___ job loss ___ discord with boss ___ discord with coworkers

___ Housing Problems: ___ homeless ___ unsafe neighborhood

___ Economic Problems: ___ extreme poverty ___ insufficient welfare support ___ bankruptcy






___ Problems with access to health care: ___ inadequate insurance

___ Problems with crime or the legal system: ___ arrest ___ litigation ___ victim of crime

___ Other social or environment problems: ___ disasters ___ war ___ discord

Comments: (Describe the nature of the stress, as well as your response or client's response, for responses above:

Important Information to include with referral:

-  Copy of current Restraining Order
-  Copy of Custody Order
-  Copy of *front and back* of Insurance Card
-  Copy Guardianship
-  Recent Clinical Assessment/Treatment Plan or Discharged Hospital Report, **if referral is being made by a mental health provider**

