SouthernMED COUNSELING

Client Referral Form

Date: _____

Client's Name: _____ Sex: _____ Age: _____

Date of Birth: _____ SSN: _____ Race:_____

Mailing Address: _____

Parent/Guardian Name (s) _____ _____

Phone (h) _____ (w)_____ (cell) _____

Name of physician/organization making the referral: _____

Mailing Address:_____

Phone:_____ Fax_____ Contact Person _____

Outside agency involvement: DJJ DSS Court/Legal Other_____

Primary Insurance Company_____ Policy ID# _____

Policyholder's Name _____ Pt./Policyholder Relationship _____

Policyholder's SSN _____ Policyholder's Date of Birth _____

Secondary Insurance Company_____ Policy ID# _____

Policyholder's Name _____ Pt./Policyholder Relationship _____

Policyholder's SSN _____ Policyholder's Date of Birth _____

Reason for Referral: Aggression Anger Anxiety ADHD Divorce Behavior Problems

Custody Depression Drug & Alcohol Eating Disorder Grief & Loss Self-Harm

Suicidal Ideation Trauma Relationship Distress Other_____

Counselor Preference: Male or Female

Additional Information:_____