A Better Way Counseling, Inc.

Quality Compassionate Care

Referral Form

**Date: Referral Source: Contact Info:**

Name: DOB: [ ] Male [ ] Female

Address: City/State/Zip:

Phone: SSN: Medicaid #:

Insurance Policy Name, Number/Group ID:

Parent or Legal Guardian Contact (if under 18):

Reason for Referral / Concerns:

Services Requested (check all that apply):

|  |  |  |
| --- | --- | --- |
| [ ] Individual Therapy | [ ] Medication Management | [ ] Infant Mental Health Counseling |
| [ ] Family Therapy | [ ] Domestic Violence Issues | [ ] Play Therapy |
| [ ] Group Therapy | [ ] Parenting Classes | [ ] Grief Therapy |
| [ ] Anger Management | [ ] ADHD Evaluation | [ ] Psychiatric Evaluation |

Is client receiving any other counseling services? [ ]Yes [ ]No

If yes, where and by whom?

Is client receiving any other community-based services? [ ]Yes [ ]No

If yes, where and by whom?

Are services mandated by court? [ ]Yes [ ]No Pending Charges? [ ]Yes [ ]No

If yes, court date?

|  |  |  |
| --- | --- | --- |
| **Please Email Form to: abwtally@gmail.com** | | **Please Fax Form to: (850) 425 - 5026** |
| **OFFICE USE ONLY** | Date Received: | Appointment Scheduled: |
| Date of insurance verification:  Active? [ ] Yes [ ] No | | Assigned Counselor: |