

REFERRAL

Date: _____ Minor Adult Family: _____ of _____

Client Information

Name: _____
 DOB: _____ Age: _____ Gender: _____ Preferred Pronouns: _____
 Ethnicity: _____ Primary Language: _____
 School Attending: _____ Grade: _____
 Employer: _____
 Home Address: _____
 City/State: _____ Zip Code: _____
 OK to send mail? YES NO

Parent/Guardian

Name: _____ Contact #: _____
 OK to leave a message? YES NO Best time to call: _____
 OK to receive text messages? YES NO
 Email: _____
 OK to receive emails? YES NO

Insurance

Medi-Cal/CalViva: YES NO If yes, ID #: _____
 CalVCB ID #: _____
 Other: _____
 Preferred days & times for sessions: _____
 Clinician Preference: Male Female Either

Session type: In person Teletherapy

Have transportation? YES NO

Appointment Reminder (can check multiple): Text Message Email Text/Phone Call & Email

Area(s) of concern (check any applicable):

- Trauma Victim Human Trafficking Family/Relationship Concerns
- Trauma Witness Runaway Bullying
- Grief Counseling Child Neglect Mental Health:
- DV Exposure Physical Abuse

Please briefly describe presenting concerns:

Suicidal Ideations? YES NO

Plan? YES NO

Have you ever received counseling before? YES NO

If yes, did your previous counselor give you a diagnosis? What were the issues you were being seen for?

Do you have a Safety Plan? YES NO

Restraining Orders? YES NO

Custody Order: YES NO

Legal Custody: _____

Physical Custody: _____

Fees for Service:

Practicum Student: \$40

Registered Associate: \$80

LMFT/LPCC/LCSW: \$120

Referral made by: _____ Agency: _____

Contact #: _____

Email Address: _____

Referrals can be submitted through email @ referral@fresnorc.org or fax @ 559-492-2903