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Mental Health Referral Form to Full Acceptance Counseling

Patient information and referring signature required. Clinical information is optional, but helpful if known, for a smooth transition to therapy.

Date of Referral: ______________ Referral Source Referring Provider Name: __________________________

Agency ________________________________ Referrer Phone number: ______________________________

PATIENT INFORMATION

Patient's Name ____ DOB ___/____/____

Patients identifying sex_________________________________Sex at birth ____________________________

Email (please print)____

Phone number_______________________________ Type of Insurance _______________________________
Member ID _____________________________ Group number______________________________________

CLINICAL INFORMATION

Reason for Referral____
____

Any known psychiatric Diagnosis, include any known substance abuse_____________________________
____

Relevant Medical Diagnoses____

Relevant Family or Social Factors ____

Current or previous suicide attempts? No Yes, and when____
Current Psychiatric Treatment & History____
Current Symptoms____
____

Additional important Information____
____
____
____

Known Current Psychiatric Medications (name & dose, attach list if preferred)______________________
____

Client consented to forwarding their information to Full Acceptance Counseling and completing this referral. Client verbally consented to receiving phone or email communication to set up their intake appointment and for therapeutic purposes. Client signed a release of authorization.

Signature of Referral Source ____ Date____________________