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| **Referral Date:** |

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| **Language Spoken in the Home:** [ ] **English** [ ] **Spanish** [ ] **Other:**  |
| **Referred by (check all that apply):** [ ] **CCSD** [ ] **COURT** [ ] **DFS** [ ] **DJJS** [ ] **PRIVATE HOME** [ ] **DCFS** |
| **Client Information:** |
| **Client's Name:**  |
| **Client's D.O.B.:**  | **Gender:**  | **Ethnicity:**  |
| **Insurance #:**  | **School:**  |
| **Parent/Guardian Information:** |
| **Parent/Guardian’s Name:** |
| **Relationship to Client:** |
| **Phone Number:**  | **Email Address:**  |
| **Address:**  |
| **Apt #:**  | **City:**  | **State/Zip:**  |
| **Services:** |
| **Reason for Referral:**  |
| **Requested Services: Please Check All That Apply:**[ ] **Assessment** [ ] **Individual Therapy** [ ] **Family Therapy** [ ] **Critical Thinking** [ ] **PSR / BST**[ ] **Anger Management / Domestic Violence Counseling**  |
| **Current / Past Treatment (Please provide any clinical documents. Ex. Assessments):** |
| **Does the Client Have an Upcoming Court Date?** [ ] **Yes** [ ] **No****If yes, please provide the Date / Time / Courtroom #:****Link:**  |
| **Referred By:**  | **Title:**  |
| **Phone:**  | **Email:**  |

You May Return This Form by Email (hardknoxramscorp@gmail.com) or Fax ((702) 820-1983)