VenusSprings
Advocacy for Community Enrichment, LLC

1380 Pantheon Way
San Antonio, TX 78232
Ste. 150
(210) 504-8597

Referral for Counseling Services

Referral Source Information:

Name: _____ Date: _____

Phone: _____ Email: _____

Please indicate your Profession:

- ❒ General Practitioner
- ❒ Nurse Practitioner
- ❒ Psychiatrist
- ❒ Counselor
- ❒ Case Manager
- ❒ Social Worker
- ❒ Other: _____

Client Referral Information:

Client's Name: _____Parent or Guardian: _____
Gender: ❒ Male ❒ Female Date of Birth: _____
Contact Number: _____
Is it ok to leave a message at this number? ❒ Yes ❒ No
If no, please provide alternative method to contact: _____

Counselor:

❒ **Kesha Martin MA, LPC, NCC, DCC**
(Online Sessions Only)
❒ **Susan Hargett, MA, LPC, NCC, E-RYT, YACEP**
(Yoga & Mindfulness)
❒**Maria Marcon MS, LPC**
(Counseling, Coaching & EMDR)
❒ **Sofia Torres, MA, LPC, NCC**
(Children, Adolescents, & Art Therapy)

The client reports history of problems and/or presents with symptoms in the following areas:

- ❑ ADHD
- ❑ Agoraphobia
- ❑ Anger Issues
- ❑ Anxiety
- ❑ Communication Problems
- ❑ Conduct Disorder
- ❑ Delusions
- ❑ Depression
- ❑ Domestic Violence
- ❑ Eating Disorder
- ❑ Hallucinations
- ❑ Homicidal Ideation
- ❑ Auditory
- ❑ Visual
- ❑ Tactile
- ❑ Hypo-Mania
- ❑ Mania
- ❑ Panic Attacks
- ❑ Post-Partum Depression
- ❑ PTSD
- ❑ Obsessive Compulsive
- ❑ Oppositional
- ❑ Relationship Issues
- ❑ Sleep Disorder
- ❑ Somatic Complaints
- ❑ Substance Abuse
- ❑ Suicidal Ideation
- ❑ Stress Management
- ❑ Other Concerns

❒ Referring person requests Therapist to call client. ❒ Patient was directed to call Therapist.

Reason for referral for treatment: **In your own words, describe the child/adult in need for mental health services. Please describe specific behaviors the child/adult is exhibiting.**_____

_____

_____

*Counseling can offer a number of health and behavioral interventions for many conditions that manifest physiologically.