Client Referral Form

Date of Referral: _____

Agency Referred from:_____
Name of Professional:_____
Phone: _____
Fax: _____
Email: _____

Does the client have knowledge of placed referral? Y or N

Client First and Last Name:_____
Client Date of Birth:_____ **Age**:_____
Address:_____
Phone (*please specify if number is for parent/guardian*):_____
Email:_____
Insurance Information:
Insurance Name:_____
Insurance ID:_____
Group Number:_____

Does the client have a legal guardian? Y or N
Name of Legal Guardian:_____

(**FOR MINORS**)
Are the minor client's parents together? Y or N
What is the custody agreement? (*please specify below*):

_____
_____

Please provide a brief description for seeking mental health services:

_____
_____
_____

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Email: mentalhealth@homegrowncounseling.org