BestPractice
PSYCHOTHERAPY
HELPING YOU MAINTAIN A HEALTHY SELF

Referral for Mental Health Services

Client's name _____ DOB _____
Address _____ Age _____
_____ ___M ___F
Phone _____

Referred by _____
Agency/Individual _____
Address _____
Phone _____

Service(s) requested

___Medication evaluation ___Individual counseling
___Physical evaluation ___Social services
___Psychological evaluation ___Testing (describe)_____
___Family therapy ___Relationship counseling
___Other_____

Background Information
Treatment history _____

_____

History of trauma (emotional, physical) _____

_____

Current diagnosis _____

Current symptoms _____

Current impairments _____

Other concerns _____