Program/Service Referral

Community Counseling Services

Rev 01/17

Case Name _____

Case Id# _____

Date _____

Program/Service Referring to _____

County Location _____

Case being referred to _____

Name of Referring Staff member: _____

Date of Referral: _____ New Consumer □Yes □ No Age _____ Sex _____

Reason for Referral _____

_____

Diagnosis:

Primary Dx _____

Secondary Dx _____

Payer/Payment Source_____ Medicaid Number: _____ (*if applicable)*

Parent or Guardian Name (if applicable):_____

Address: _____

Phone Number: _____

Cell Number: _____

Best time to Contact: _____

School Attended (child only)_____

Directions to home:

_____

_____

_____