Referral for Therapeutic Counseling

Email: referrals@pcahabersham.org
Phone: 706-778-3100 ◆ **Fax:** 706-928-5183

REFERRED BY:	**PHONE:**	**DATE:**

Client's Name:	**Client #** OFFICE USE ONLY

Age	DOB	Gender	Race	Ethnicity Hispanic? ☐ Yes ☐ No
Grade	School			Disability? ☐ Yes ☐ No

CONTACT INFORMATION

Contact Name	Relationship
Best contact number	☐ Cell ☐ Home ☐ Work
Can contact be made by text? ☐ Yes ☐ No	Can we leave a voice mail? ☐ Yes ☐ No
Email address	Can paperwork be emailed? ☐ Yes ☐ No
Address	Availability: Sun.-Sat.

City	State	Zip	County

Annual Household Income	Insurance Coverage

BACKGROUND

Are they, or have they been enrolled in services with the Family Resource Center? ☐ Yes ☐ No

If yes, what program?	Date exited services
Was client ever convicted of a crime against a child? ☐ Yes ☐ No	If yes, when?

VICTIMIZATION *(Form of Adverse Childhood Experience)* Check all that apply:

CHILD – *Incident occurred in the last 5 years*		**ADULT –** *Incident occurred in childhood*	
☐ **Parents divorced/separated**	☐ **Bullying**	☐ **Parents divorced/separated**	☐ **Bullying**
☐ **Abandonment**	☐ **Pornography**	☐ **Abandonment**	☐ **Pornography**
☐ **Parental Substance Abuse**	☐ **Parent Mental Health**	☐ **Parental Substance Abuse**	☐ **Parent Mental Health**
☐ **Traumatic Grief**	☐ **Incarcerated Parent**	☐ **Traumatic Grief**	☐ **Incarcerated Parent**
☐ **Other:**		☐ **Other:**	

REASON FOR REFERRAL

Any major concerns (*Suicidal ideations cutting etc.*):

Assigned to:____ **Date:** _____/____/_____
OFFICE USE ONLY