# REFERRAL FOR COUNSELING

## Fax to: (954) 324-8354

DATE: _____

REFERRED BY: _____

PHONE: _____

COMPANY/ROLE: _____

CLIENT NAME:_____

CLIENT PHONE: _____

CLIENT ADDRESS:_____

City and State: : _____

ALF/IL Community: _____

Primary Language: _____

MEDICARE#: _____ DOB:_____ / ___ /_____

SUPPLEMENTAL INSURANCE PLAN AND TYPE: _____

SHOULD POA/FAMILY BE CALLED FIRST? _____

POA NAME:_____ POA PHONE:_____

REASON FOR REFERRAL:_____

☐ Adjustment ☐ Anxiety ☐ Depression ☐ Bereavemen ☐ Other:_____

ATTACHED DOCUMENTS:

☐ Face Sheet ☐ Medicare card ☐ Medication List

☐ Other:_____