

# GREEN LIGHT COUNSELING, INC.

## Client Referral Form

Referral Date: \_\_\_\_\_

### External Referring Source

Name: \_\_\_\_\_ Agency name, if applicable: \_\_\_\_\_

Contact #: \_\_\_\_\_  Home  Work  Cell

Email address: \_\_\_\_\_ Relationship of Caller to Consumer: \_\_\_\_\_

Inquiring about:  Intensive In-Home  Day Treatment  Community Support Team  
 Outpatient Therapy  Comprehensive Clinical Assessment  Medication Management  
 Targeted Case management  Unknown

### Internal Referring Source

Employee Name and Title: \_\_\_\_\_ Phone #: \_\_\_\_\_

### Client Information

Name: \_\_\_\_\_ Gender:  M  F DOB: \_\_\_\_\_ Age: \_\_\_\_\_

Contact #: \_\_\_\_\_  Client or  Guardian

Race: \_\_\_\_\_ SSN: \_\_\_\_\_ Medicaid ID: \_\_\_\_\_

Address: \_\_\_\_\_ City/State/Zip: \_\_\_\_\_

Guardian: \_\_\_\_\_ Relationship to Consumer: \_\_\_\_\_

Address: \_\_\_\_\_ City/State/Zip: \_\_\_\_\_

### Reason for Referral:

---

---

---

---

---

### Agencies or Professionals Currently Involved:

Name: \_\_\_\_\_ Agency: \_\_\_\_\_ Phone #: \_\_\_\_\_

Name: \_\_\_\_\_ Agency: \_\_\_\_\_ Phone #: \_\_\_\_\_

### Diagnostic Information

Axis I: \_\_\_\_\_

Axis II: \_\_\_\_\_

Date of diagnosis: \_\_\_\_\_

No diagnosis available