TJocelyne Counseling & Consulting Group

Please **Fax** the referral form to Intake **888-506-6021**
Phone 508-580-0364, 425 Pleasant Street 1st FL, Brockton, MA 02301

Referring Agency/Office / Clinic Information

Name of referring Agency_____**Todays Date:** _____

Agency/facility fax number _____Phone contact number_____

Name of clinician completing form _____Agency/facilty address_____

Referred Client/Patient Information

First name_____ Client last name _____DOB _____Age_____

Home address_____ City _____Zip code_____

Cell phone number _____ Email Address _____

Prim Insurance Name _____ Insurance ID number_____Ins. Phone number_____

Second. Insurance Name _____Insurance ID number_____Ins. Phone number_____

Guardian's Name _____DOB of Parent/Subscriber_____

Reason for Referral (please underline or circle you desired service)

Marital/*Couple Therapy* Y N Adult Individual /Fam Therapy Y N Child Therapy Y N Group Therapy Y N

Current Therapist name_____(if applicable) Phone number _____

Primary mental health diagnosis/ challenges_____

Medical issues (if applicable) Y N _____

Substance abuse/ Alcohol issues (if applicable) Y N_____

Current Medication Regimen

Drug name	Dose	Instructions	Reason	Efficacy

Did the client consent to releasing personal health information to TJocelyne Counseling? Y N if not please skip the questions below

Client/Guardian's Signature: _____

Please rate the identified client/couple/family's concern (s) below 1= MILD 2= Moderate 3=Severe:

Depression 1 2 3 **Anxiety** 1 2 3 **Anger** 1 2 3 Trauma 1 2 3 **Low Self -Esteem** 1 2 3

Does this concern affect functioning in any of these areas and how 1=MILD 2=Moderate 3= Severe

Work 1 2 3 **Family** 1 2 3 **Relationships** 1 2 3 **Academic** 1 2 3 **Social Network** 1 2 3 Legal 1 2 3