

COUNSELING REFERRAL FORM

Client Name: _____ Client ID: _____

Referral Information:

Referring Counselor/Professional: _____

Referral Reason / Presenting Problem: _____

Additional Information / Comments:

Client Information: _____

Date of Birth: _____ Gender: _____

Phone Number: _____

Email Address: _____

Insurance Information:

Insurance Provider: _____

Policy Number: _____

Referral Details and Instructions:

The client is referred for counseling services as outlined herein. Referring professional certifies that the information provided is accurate and that this referral is made with the client’s consent or as legally permissible. All counseling services shall comply with applicable United States laws, including confidentiality requirements under HIPAA and applicable state regulations.

Referral Purpose:

Please select the primary reason(s) for referral (check all that apply):

- | | |
|--|--|
| ☐ Anxiety / Stress Management | ☐ Marital / Family Issues |
| ☐ Depression / Mood Disorders | ☐ Substance Use |
| ☐ Behavioral Issues | ☐ Trauma / PTSD |
| ☐ Career / Academic Concerns | ☐ Grief / Loss |
| ☐ Other: _____ | |

Referral Authorization and Signature:

I certify that I am authorized to make this referral and that all information provided herein is true and accurate to the best of my knowledge. I acknowledge that the counselor will maintain confidentiality and will provide counseling services in accordance with applicable laws and ethical standards.

Referring Professional Signature:

Client/Guardian Signature:

Signature: _____

Signature: _____

federal and state laws governing confidentiality, professional conduct, and client rights. By signing, parties acknowledge understanding and acceptance of such legal requirements and responsibilities.

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