JOURNEY
Counseling & Community Services, LLC

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REFERRAL FORM

(Please Print)

Service Request: ☐ **FFT** (age 10-18) ☐ **CPST/ PSR** Ages 6+ (Children, Adolescents & Adults)

Today's Date: ____/_____/_____ Client Name: _____
First Middle Last

Date of Birth: ____/____/_____ Age: _____ Gender: _____

Address _____ City, State, Zip: _____

Parent/ Guardian _____ Parent/ Guardian_____

Home/ Cell Phone _____Work Phone_____ Alternate Phone _____
Permission to Leave Message: Home/Cell ☐ YES ☐ NO Work ☐ YES ☐ NO Alternate ☐ YES ☐ NO

Best contact time: ☐ Morning (8am-11am) ☐ Afternoon (noon-3pm) ☐ Evening (4pm- 7pm) ☐ Anytime

PRESENTING PROBLEMS(s): Please check all that apply and provide brief explanation
☐ Behavioral concerns at home/school
☐ Depression/ self-esteem/ cutting
☐ Life issues/ problems
☐ Family Conflict/ Relationship Problems
☐ Physical aggression
☐ Trauma
☐ Anxiety
☐ Parenting
☐ Substance Abuse
☐ Other

PAST TREATMENT:

Has the client been diagnosed with a behavioral or mental health disorder in the past? If yes, previous diagnosis?

REFERRAL SOURCE:

Referral Agency: Please select one Select One

Referral Name: _____ **Phone number**: _____ **Email:** _____

Please return referral via email: jccsadmin@journeyccservices.com **OR fax 985-467-0730**