# **Guest House Counseling Clinic Referral Form**

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| **Section 1: To be completed by Referring Case Manager or Clinician**  ***All other referrals will be contacted directly by a clinician*** |

**Please complete all information**

**Referral Date:** Click or tap here to enter text.

**Client Name:** Click or tap here to enter text. **Phone Number:** Click or tap here to enter text. **DOB:** Click or tap here to enter text.

**Insurance:** Click or tap here to enter text. **SSN:** Click or tap here to enter text.**Email:** Click or tap here to enter text.

1. **Referral Source:**Click or tap here to enter text.

**Referring Provider Name:** ­Click or tap here to enter text.**Contact Info:** ­Click or tap here to enter text.

**Shelter Resident**   **Other GH Program (Name):** Click or tap here to enter text.

**External Client  Insurance Referral  Hospital Referral**

**Community Agency:** Click or tap here to enter text.

**Probation/Parole Officer**

1. **Reason for Referral (Check all that apply)**   
    **Psychotropic Medication Management**

**Mental Health (Individual and/or group)**   
 **Substance Abuse (Individual and/or group)**

**Intoxicated Driver Program**

1. **Does Client CURRENTLY have an outpatient Mental Health or AODA Therapist?**

**No**  **Yes- Explain:** Click or tap here to enter text.

1. **Provide additional collateral information regarding the reason for the referral:** Click or tap here to enter text.
2. **Are there any provider preferences?** Click or tap here to enter text.

**Signature of Referring Provider \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_** **Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**\* Please Attach Signed ROI with referral**

**PLEASE FAX COMPLETED FORM TO (949) 703-8118**