Referral Form

Horse Sense of the Carolinas, Inc.

Client Name_____ Age:_____ D.O.B:_____ SS#_____ ____ _____ M / F

Address:_____ _ City & State:_____ Zip Code:_____

Home Phone:_____ Work Phone:_____ Cell Phone:_____ Message OK? Y / N

Caller Name:_____ Phone#_____ Relationship to Client:_____

Legal Guardian: (must sign all paperwork)

Legal Guardian phone numbers: H_____ W _____ C_____

Reasons seeking therapy:_____

_____

Previous Treatment?_____Provider: _____

_____

Existing Diagnoses? _____

Psychiatric Hospitalization in past year? _____

Legal Involvement:_____ On probation? Y / N

Medications: _____

Prescribed by:_____ Current Therapist:_____

Medical Issues we should know about: _____

Referring Organization/Contact Person: _____

Who will provide transportation? _____

Please Mark Funding: [ ] Self-Pay/Private Ins. (payment due at session) [ ] Medicaid [ ] Grant [ ] Scholarship Fund (waiting list)

For Office Use Only

If Phone Screening: Answered by:_____ Date:_____

Client Contacted for Intake by:_____ Date:_____

Intake Made for this date and time:_____ with this therapist:_____

If Outside Referral: Fax Received by:_____ Date:_____

Client Contacted for Intake by:_____ Date:_____

Intake Made for this date and time:_____ with this therapist:: _____

Referral Source:_____

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