**Crossroads Counseling Referral Form**

Client Name: _____ Date: _____

Date of Birth: _____ SS#_____ Gender: _____

Home Phone: _____ Cell Phone: _____

Race: _____ Marital Status _____ Employer/School:_____

(For Minors Only) Parent/Guardian: _____

Relationship to Child: _____ Phone: _____

Address: _____

Primary Language_____

DJJ Involvement? _____ DCF Involvement? _____

Previous Counseling? (where, when?)_____

Baker Acts/Hospitalization? _____

With whom does child reside? _____

Insurance Plan: _____ ID Number: _____

Group No:_____ Primary Insured's Name:_____

DOB: _____

Other Forms of Payment: _____ Self-pay

Reason(s) for Referral:

_____

_____

Referral Source (Name) _____

Agency (Outside referral source):_____

Phone Number: _____Email: _____

Relationship to Client: _____