BREATHE
Holistic Counseling, Inc.

REFERRAL FORM

Demographic Information

Name:	**Date of Birth:**
Street Address:	**Gender:** **Gender Identity:**
City, State, Zip Code:	**Home Phone:**
Insurance Provider:	**Insurance ID #:**
Email Address:	**Mobile Phone:**
Emergency Contact Person:	**Emergency Contact Phone:**
Parent/Guardian:	**Relationship to Client:**

Referral Agency/Source: _____

Referring Clinician/Referred by: _____

Referral Source phone # and email: _____

Referral Diagnosis: _____

_____

Medications/Dosage/Prescribed for:

_____

_____

_____

Prescriber: _____

Prescriber Contact Information: _____

Medication Compliant?: _____

Current Living Situation: _____

Client Strengths: _____

_____

_____

_____

Resources that would benefit client:

_____

_____

_____

Recent hospitalization ☐No ☐Yes

History of Suicidal Ideations ☐No ☐Yes

History of Homicidal Ideations ☐No ☐Yes

History of Psychosis ☐No ☐Yes

History of Substance Use ☐No ☐Yes

If yes to any of these questions, please explain in detail in the reason for referral section.

Reason for Referral (Please include your assessment of client's needs, recent hospitalization, recent crisis, legal issues, psychosocial stressors, barriers to treatment and other concerns. Please a separate sheet, if necessary)

_____

_____

_____

_____

Please email referral to breatheholistic.@outlook.com or fax to (410) 444-6824

Thank you for your referral to Breathe Holistic Counseling, Inc.!