**Referral Form**

Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Time: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_am/pm

|  |
| --- |
| Information for Person Being Referred |
| Name |  |
| Reason  | Counseling/ Therapy  |  | Family Services  |  | Mentoring/ Community Resources  |
| Please Describe |  |
| Contact Information | Cell |  | Work |  | Home |  |
| If minor, parent/guardian name |  |

|  |
| --- |
| Information for Referral Source |
| Name of Agency |  |
| Person to Contact |  |
| Contact Information | Cell |  | Work |  |

\*Please email a “Consent to Release Information” so that we may communicate with you regarding your referral. cmorales@elpasocares.org

***Office Use Only***

|  |  |
| --- | --- |
| Date referral received |  |
| 1st contact attempt | Date/Time |  | Result |  |
| 2nd contact attempt | Date/Time |  | Result |  |
| 3rd contact attempt | Date/Time |  | Result |  |
| Consent from referral agency received |  | Yes |  | No |
| If yes, was referral agency contacted? |  | Yes |  | No |