**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 |