CALISSA'S COUNSELING SERVICES

3580 Main St♦Building #11♦Suite E♦Hartford, CT 06112
Phone: (860) 778.5317♦ Fax: (860) 219-0100

New Referral Form

Client Demographics:

Date of Referral: _____ Referral Source: _____ Is Client a Minor?: ☐ Yes ☐ No

Client Name: _____ Date of Birth: _____ Phone #: _____

Mailing Address: _____ City: _____ State: CT Zip: _____ Email: _____

Client's Caregiver Information:

Not Applicable: ☐

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

Address: _____ City: _____ State: CT Zip: _____

Insurance Information:

Insurance Carrier #1: _____ ID#: _____ SS#: _____ Verified: ☐ Yes ☐ No

Comments: _____

Name of Insured: _____ DOB of Insured: _____ Behavioral Health Phone#: _____

Insurance Carrier #2: _____ ID#: _____ SS#: _____ Verified: ☐ Yes ☐ No

Comments: _____

Name of Insured: _____ DOB of Insured: _____ Behavioral Health Phone#: _____

Presenting Problems:

_____

Areas Affected:

☐ Home ☐ Work ☐ School ☐ Social ☐ Legal

Ideations/Behaviors:

☐ None ☐ Suicidal ☐ Homicidal ☐ Self-Harming ☐ Hallucinations ☐ Delusions

Does client have a plan in place? ☐ Yes ☐ No

If yes, action taken:

_____

Client Preferences:

☐ In-Home ☐ In-Office ☐ Female Clinician ☐ Male Clinician ☐ No Preference

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☐ English ☐ Spanish ☐ Weekdays ☐ Weekends ☐ Daytime ☐ Evening

Client Availability:

Days: **Hours:**

☐ Mon ☐ Tue ☐ Wed ☐ Thu ☐ Fri ☐ Sat ☐ Sun ☐ AM ☐ PM

Comments: _____

Comments:

_____

Name/Signature of Person Completing Referral: _____

Title: _____ **Referring Agency:** _____ **Address:** _____

Phone: _____ **Email:** _____

Thank you for your referral!

Please make sure to include contact phone number for the client. If the client is a minor, please include contact phone number for the parent/guardian as well.

Please feel free to fax this referral to our confidential fax at (860) 219-0100 or you can email it directly to my attention: Calissa Welch @ CWelch@calissascounseling.com

Calissa N. Welch, LCSW
Clinical Director
(860) 778-5317