\*Please contact Evolution Counseling Services, LLC at (814) 201-2751 or fax to (814) 201-2758

|  |  |  |
| --- | --- | --- |
| **DATE OF REFERRAL** | **REFERRAL SOURCE** | **REFERRAL CONTACT #** |
|  |  |   |
| **MEDICAL ASSISTANCE # or PRIMARY INSURANCE PROVIDER****\*Please attach a copy of the front and back of the primary client’s insurance card\*** |
|  |

|  |
| --- |
| **PRIMARY CLIENT** |
| **FULL NAME** | **DOB/ AGE** | **SSN** |
|  |  |  |
| **STREET ADDRESS** | **CITY, STATE, ZIP** |
|  |  |
| **EMAIL ADDRESS** | **HOME PHONE** | **CELL PHONE** |
|  |  |  |
| If child/adolescent, who has legal custody of the client? |  |
| Where does the client currently reside? |  |

|  |
| --- |
| **REASON FOR REFERRAL** |
|  |
| **CLIENT & FAMILY STRENGTHS** |
|  |
| **SERVICES CURRENTLY INVOLVED WITH CLIENT/FAMILY** |
|  |
| **MENTAL HEALTH DIAGNOSIS** |
| Explanation: |
| Medication: |
| **FAMILY & HOUSEHOLD** |
| **Parent/Guardian Name** | **Relationship** | **Age** |
|  |  |  |
|  |  |
| **Parent/Guardian Name** | **Relationship** | **Age** |
|  |  |  |
| History of substance abuse, violence, or mental health involvement? |  |
| Number of Siblings Living in the home: | Other Key Supports: |