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REFERRAL FORM FOR THERAPEUTIC SERVICES

DATE _____

REFERRAL SOURCE (AGENCY/PERSON) _____

ADDRESS _____ PHONE _____

FAX NUMBER _____ EMAIL ADDRESS_____

CLIENT'S NAME _____ DOB _____

LEGAL GENDER_____ PRONOUNS_____ AGE _____ ETHNICITY _____

ADDRESS _____

HOME PHONE (_____) _____ WORK HOME (_____) _____

DIAGNOSIS:

_____

_____

□ **BIOLOGICIAL PARENT** □ **LEGAL GUARDIAN (MUST PROVIDE LEGAL DOCUMENTS FOR VERIFICATION)**

PARENT/GUARDIAN/OTHER _____

HOME PHONE (_____) _____ WORK HOME (_____) _____

PARENT/GUARDIAN/OTHER _____

HOME PHONE (_____) _____ WORK HOME (_____) _____

OPEN OCS CASE? _____ OPEN CUSTODY CASE?_____ CLIENT'S INSURANCE: _____

REASON(S) FOR REFERRAL (CHECK ALL THAT APPLY)

□ PARENT SUPPORT □ INDIVIDUAL THERAPY □ FAMILY THERAPY □ GROUP THERAPY
□ EMDR □ PLAY THERAPY □ EXPRESSIVE ARTS THERAPY □ TF-CBT
□ ASSESSMENT

BRIEF DESCRIPTION OF PROBLEM (ATTACH SEPARATE SHEET IF NECESSARY. PLEASE FORWARD MEDICAL & BEHAVIORAL INFORMATION, COURT REPORTS, SOCIAL SUMMARIES, PREVIOUS EVALUATIONS, ETC.)

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PLEASE FAX THIS COMPLETED FORM TO (907) 561-0225 OR
MAIL TO 4141 B STREET, SUITE 301, ANCHORAGE AK 99503

Office Only: