1313 Quarrier Street
Suite B
(304)981-1412

KYFC Comprehensive Counseling Referral Form

Client Name: ______________________________ **Date of Birth:** ______________________________

SSN: ______________________________ **Phone:** ______________________________

Address: ______________________________

Email Address: ______________________________ **County of Residence:** ______________________________

Parent/Guardian Name: ______________________________ **Phone:** ______________________________

Email Address: ______________________________

Insurance Policy: ______________________________ **Policy Number:** ______________________________

Policy Holder Name: ______________________________ **Effective Date:** ______________________________

Member ID: ______________________________ **Group Number:** ______________________________

Policy Holder Name: ______________________________ **Relationship to Client:** ______________________________

Date of Birth: ______________________________ **SSN:** ______________________________

Self-Referral ______ **Court Ordered/Mandated Referral** _____ **Other Referral Type:** ______________________________

Contact Person for Mandated Referral: ______________________________

Symptoms presentation current and by history. Check all that apply

- ☐ Depression
- ☐ Problems with sleep
- ☐ Crying spells
- ☐ Isolation/withdrawal
- ☐ Anxiety
- ☐ Stomach/muscle tension
- ☐ Irritability
- ☐ Aggression/anger
- ☐ Trauma exposure
- ☐ Fear
- ☐ Nervousness
- ☐ Parenting support
- ☐ Problems with family/peer interaction
- ☐ Professional or academic support
- ☐ Marriage and couples counseling
- ☐ Recovery and relapse prevention
- ☐ Bed wetting
- ☐ Nightmares

Please describe any additional/supportive information:

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