1759 West Broadway St, Suite 3
Oviedo, FL 32765
Phone: 407-977-4335 Fax: 407-977-4370
www.resiliencecc.com

REFERRAL FOR COUNSELING SERVICES

Date_______________

Client's First Name_____________________ Last Name____________________________ MI_________

Name of Parent/Guardian if applicable____

Address_____________________________________ City_________________ State_____ Zip_______

Telephone (Home)________________________ (Cell)______________________________________

E-mail: ____

Birth date______/______/______ Gender __F __M

Insurance Plan: ______________________________ Policy #: ____________________________________

Reason for Referral:

☐ Anxiety	☐ Depression	☐ Inattentiveness	☐ Impulse Control
☐ Panic Attacks	☐ Self Mutilation	☐ Social Skills	☐ Anger Management
☐ Noncompliance	☐ PTSD Symptoms	☐ OCD Symptoms	☐ Phobia _____
☐ Eating Disorder	☐ Legal	☐ Sexual Issues	☐ Separation /Loss
☐ Self-esteem	☐ Substance Abuse	☐ Family conflict	☐ Hallucinations
☐ Sleep Issues	☐ Nervousness/Tension	☐ Relationship Issues	☐ _______________

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Has the client been made aware of the referral to Resilience Counseling Center, Inc.? _________________

Is a Release of Information form attached so that we may inform you of the outcome of the referral? ___________

Referred by:

____ ______________
Signature Date

____ ____________________________________
Printed Name and Title Agency Name

Phone: ____ Fax: ________________________________

E-mail: ____

Please fax this form to 407-977-4370 or e-mail it to info@resiliencecc.com