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Referral Form – Del Rio, TX Office

Date: _____ Reason for referral: _____

Referral Source and Contact #: _____

Crisis: Yes No (if crisis, please call) See Within: 48hrs 1 week Next Regularly Available

Client's Name: _____ Phone: _____

If client is a minor, Parent/Guardian name: _____

DOB: _____ Male Female Other _____

Address: _____ City: _____

Insurance: Yes No Type of Insurance: _____

Services Requested:

- ADHD
- Anger
- Anxiety / Panic
- Behavioral Problems
- Bipolar disorder
- Career Counseling
- Cognitive Behavioral Therapy for Insomnia
- Cognitive Behavioral Therapy for Weight loss
- Couples Counseling / Relationship Issues
- Depression
- Domestic / Family Violence
- Family counseling
- Grief/Loss
- Group therapy
- Health/Pain issues
- Play therapy
- Psychosis
- PTSD/Abuse/Trauma/Rape
- Sexual Orientation/Gender Identity/other issues
- Substance use issues
- Veteran/Family Program (anyone who has ever been in the military or their family is eligible)
- Other: _____

Specific Therapist Request: No preference Spanish Speaking Other _____

- Alejandra Pulido, LPC Intern (bilingual)
- Gisela Rivera, LCSW (bilingual)
- Kayla Nettleton, LMSW (veteran/family only) (bilingual)
- Norely Sorrell, LPC (bilingual)

Date Received: _____ **Date Called:** _____ **Who Made Contact:** _____

Appointment Made: Y N **If No, Reason:** _____