WEST TEXAS COUNSELING & GUIDANCE

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Del Rio, TX 78840
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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
- ☐ 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_____

- ☐ Stephanie Blancarte, LCSW
- ☐ Alejandra Garcia, LPC, RPT (bilingual)
- ☐ Daniel Perez, LPC (bilingual)

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

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