Alternative Therapy, LLC

A Professional Counseling Service

Referral Information

Please indicate one below:

This is a referral to Alternative Therapy, LLC (include signed release) _____

Complete the following referral form and fax to (203)248-5312.

For information call (203)281-0300.

Or

This is a referral to another agency by Alternative Therapy, LLC _____

Agency: _____ Date of Referral: _____

Client's Name: _____

Date of Birth: _____ Place of Birth: _____

Parent /Legal Guardian (if under age of 18): _____

Contact Information: Cell #: _____ Home #: _____

Address: _____

_____

Primary Insurance Carrier: _____ ID #: _____

Secondary Insurance Carrier: _____ ID#: _____

Emergency Contact Name: _____ Contact Number: _____

Relationship to Client: _____

If referral is to Alternative Therapy, LLC from another agency, please provide the name of person making this referral: _____

Referring Agency Name: _____

Phone #: _____ Fax #: _____

Primary reason for referral:

_____

_____

_____

_____

_____

Goals and expectations of treatment:

_____

_____

_____

_____

_____

Family history, family psychiatric & substance abuse history, current family stressors that may be affecting client:

_____

_____

_____

_____

_____

Religious/Cultural background. Including related special need/restrictions if applicable:

_____

_____

_____

_____

_____

If client is in school, please provide the following information:

School Name: _____ Address: _____

Grade: _____ Special Ed. Status (if any): _____

School Contact Person: _____ Tel #: _____

Reported academic and/or behavioral issues in school:

_____

_____

_____

_____

_____

Please check all that apply:

Any current/past DCF involvement: _____

If Yes, please describe history of placement including dates.

_____

_____

_____

Any current adult/juvenile court involvement: _____

Probation Officer: _____ Tel #: _____

Current Service Providers:

Name of Provider	Agency/Facility	Phone Number	Service Provided	Dates of Participation

Previous Mental Health Treatment:

Name of Provider	Agency/Facility	Phone Number	Service Provided	Dates of Participation

Primary Care Physician: _____ Phone #: _____

Medical issues:

_____

_____

_____

Current DSM V (ICD-10) TR Diagnosis (if known):

Axis I. _____

Axis II. _____

Axis III. _____

Axis IV. _____

Axis V. M/GAF (current): _____ M/GAF (highest w/ in past year):_____

_____ _____

Signature of Person Making Referral Date Referral Form Completed

If this is a referral from a provider to Alternative Therapy, LLC, please attach any available clinical information including a signed release of information authorization.

Please fax this form to (203) 248-5312. Attn: Referrals