Please return completed forms to:
Fax #: (802) 660-0576 or
hello@riverstonecounseling.org

If sending by email, please note that email is not a secure form of communication.

For ?'s call us:
(802) 864-7423, x310

REFERRAL FORM

Please note that all sections of this form must be completed in full.
If information is missing, the form will be returned, which may cause a delay in processing.

CLIENT INFORMATION

Date:_______________

First Name: ___________________________ Last Name: _______________________________________

Gender: ____________________ Sex at birth: ______________________ Pronouns: ________________

Date of Birth: ________ Social Security#: _______________ Mother's Maiden Name:_______________

Current Address: ____

City: ____________________________ State: _________________________ Zip: ____________________

Phone #_____________________________ Email: ____

Best way to contact me: Phone ☐ E-mail ☐ Text ☐

Okay to leave a message? YES ☐ NO ☐

How would you like appointment reminders? Text ☐ Email ☐

Please list your availability for scheduling: ____

REFERRAL SOURCE : if self-referral skip this section

Name/Organization:____

Address: ____

Phone #: _____________________________ Email Address: ____________________________________

Fax #: _______________________________

CONTACTS

Emergency Contact: _______________________________ Phone #: _____________________

Relationship to Client: ______________________________

Please list parent/guardian information below if the client is under 18:

Parent/Guardian Name: ____________________________ Phone #: _____________________

Parent/Guardian Name: ____________________________ Phone #: _____________________

INSURANCE INFORMATION (please attach front and back copies of the insurance card)

Insurance Company: ___________________________________ Insurance ID #: ______________________________

Group #: ______________________________ Insurance Company Phone #: _________________________________

Subscriber Name: ____

Subscriber Date of Birth: ____

Subscriber Address: ____

BILLING INFORMATION

Name of Responsible Person: ____________________________________ Phone Number: ____________________

Email Address: ____

Mailing Address: ____

City: __________________________________ State: __________________________________ Zip: ______________

REASON FOR REFERRAL (check all that apply)

☐ Clinical Assessment ☐ Mental Health Treatment ☐ Substance Use Treatment

☐ Family Therapy ☐ Parent Support ☐ Other _____________________________

Intravenous Drug User: YES ☐ NO ☐ Pregnant: YES ☐ NO ☐

Brief Description of Reason for Referral: If more space is needed, please attach it. Please attach any Medical & Behavior information, court reports, social summaries, previous evaluations, etc.

____

____

____

NEEDS FOR ACCESSIBILITY

☐ Interpreter (specify language)____

☐ Accessible Room (describe) ____

☐ Other Special Needs (specify) ____

RACE (make a checklist)

☐ American Indian/Alaska Native ☐ Asian ☐ Black or African American

☐ Native Hawaiian or Pacific Islander ☐ White ☐ Biracial ☐ Other ☐ Decline to answer/Don't know

ETHNICITY: (make a checklist)

☐ Hispanic/Latino ☐ Non-Hispanic/Non-Latino ☐ Decline to answer/Don't know

Client's Primary Language: _________________________________ Are you currently in school? YES ☐ NO ☐

Highest grade/education completed? ________________________

Are you currently employed? YES ☐ NO ☐ Please check: ☐ Full-time or ☐ Part-time