Family Therapy and Renewal Center

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PRIORITY: _____**Low** (schedule within 1 month) _____**High** (schedule within 2 weeks) _____**Emergency** (schedule asap)

CONFIDENTIAL REFERRAL FORM

Client's Name:_____ **Date of Birth:**_____
First Middle Last

Parent/Guardian Name_____ **Home Phone: (___)_____**

Work Phone: (___)_____Cell Phone: (___)_____ Referred by: ____Self _____Parent
_____School _____Probation
____DHS _____Other

Client Lives with:_____

Reason(s) for Referral-Problems/Concerns related to: (please check all that apply)

☐Recent or Historical Trauma	☐Anxiety/nervousness	☐Drug/Alcohol Abuse	☐Change in Behavior or Mood
☐Worries	☐ Self-Harm	☐Depression	☐Aggression/Anger
☐Grief	☐Oppositional/Defiant	☐Peer Relational Issues	☐Social Skills
☐Fears	☐Boundaries	☐Lying	☐Stealing
☐Sadness	☐Chews (paper/hair/clothes)	☐Destruction of Property	☐Motivation
☐Extreme tiredness	☐Concentration	☐Impulsive	☐Bullying/ Bullied
☐Makes Odd Sounds	☐Self-Image/Confidence	☐Over-Active	☐Family Concerns
☐Withdrawn	☐Highly Sensitive	☐ Perfectionist	☐Sexual Acting Out

Clarify Referral Problem/History:

_____
_____
_____
_____
_____
_____

Name of Person Making Referral:_____ **Relationship to Client:**_____
Will you need progress/treatment updates? ☐YES ☐ NO How Often? ☐Monthly ☐Quarterly ☐Mid & Post Treatment
How would you like to receive the referral?
☐Fax (number)_____ **☐Email (address)**_____ **☐Mail (address):**_____

Signature of Person Making Referral:_____ **Date of Referral:**_____

This form may be returned confidentially by Fax: (918) 369-4951 or Email: info@ftrctulsa.org

For more information on Family Therapy & Renewal Center and our staff visit our website at www.ftrctulsa.org