Aspiring Hearts Counseling, PLLC
Mending Hearts... Changing Lives.

REFERRAL FORM

Please complete ALL fields and submit completed form by fax or email.
Fax: 1-888-325-6160 Email: Info@aspiringhearts.com

Referral Date: ____________

Prospective Client Information

Name: ____________ Date of Birth: ____________
Social Security Number: ____________ Medicaid Number: ____________
Insurance Company: ____________ Policy Number: ____________
Address: ____________
Phone 1: ____________ Phone 2: ____________
Best Time to Call: ____________ Race: ____________
Transportation:
☐ Own Vehicle ☐ Public Trans. ☐ Medicaid Trans. ☐ Friends/Family ☐ None

Service Referral

☐ Individual Outpatient Therapy
Subcategories:
☐ Family Therapy ☐ Couples Therapy ☐ Mental Health Assessment Only

☐ Group Therapy (Note: Group therapy cannot occur without multiple participants.)
Group:
☐ Parent Skills Training ☐ Social Skills ☐ Self-Esteem ☐ Anger Management
☐ Other:

Please Complete if Prospective Client is Under Age 18 or Has a Legal Guardian

Grade Level: ____________ School Name: ____________
Parent or Guardian Name: Relationship:

Referral Source Information

Name: ____________ Agency: ____________
Contact Number: ____________ Fax Number: ____________
Address: ____________
Email Address:

Clinical and Case Information

Reason for Referral (Please list problems, symptoms, and behaviors):

Psychosis: ☐ Yes ☐ No ☐ Unknown Anger/Aggressive: ☐ Yes ☐ No ☐ Unknown

Suicidal Ideations: ☐ None ☐ Current ☐ Past ☐ Recent Attempt ☐ Past Attempt(s)

Homicidal Ideations: ☐ None ☐ Current ☐ Past ☐ Recent Attempt ☐ Past Attempt(s)

Safety Concerns: ______________________

Abuse: ☐ None ☐ Physical ☐ Sexual ☐ Rape ☐ Domestic Violence ☐ Unknown

Drug/Alcohol Abuse: ☐ None ☐ Current ☐ Past ☐ Unknown

Psychiatrist: ______________________

Mental Health Medication:

Recent Mental Health Services: ☐ None ☐ Unknown

☐ Outpatient Therapy Agency/Therapist: ______________________

☐ Intensive In-Home Agency: ______________________

☐ Targeted Case Management Agency: ______________________

☐ Community Support Team Agency: ______________________

☐ Hospitalizations Hospital: ______________________

☐ Other: Agency:

Diagnoses: ______________________

Medical Conditions: ______________________

CPS Involvement: ☐ No ☐ Yes ☐ Past Worker: ______________________

Are Services Court Ordered: ☐ Yes ☐ No

Therapist Preference (Preference Cannot be Guaranteed):

Additional Comments