**CLINICAL COUNSELING REFERRAL FORM**

 Please complete the following and send this form, and any additional information to:

office@empoweringchoicescc.com or fax to: **503-589-3179**

 **ATTN: Front Desk, Office number: 503-589-3112**

805 Liberty St NE Suite 2 Salem, OR 97301

Person/Agency:

Phone Number:

Email:

|  |
| --- |
| **Referring** **Demographics**Clients Name: Insurance Type: Client Address: Policy Number: City/State/Zip: Group Number: Date of Birth/Age: Policy Number (s): Parent or Caretaker Name: Phone number:  |

Assessment (With Services – Specify Services Desired Below)

[ ]  Child:

[ ]  Adult:

Services Requested (Assessment Required; Services based on medical necessity and as authorized by payment source).

Requested Services (Mark all that apply)

Assessment (With Recommendations Only, No Services)

[ ]  Child:

[ ]  Adult

Doctors Office Referring: Doctor’s Name:

Psychotherapy/Counseling Family Support (consultation)

[ ] Individual [ ] Understanding Autism

 And how to support a child/children on the spectrum

[ ] Family [ ] Life Coaching (Life changes/Life Transitions)

[ ] Group [ ] Parenting Coaching

Assessments Adult Child

 [ ] Psycho-Social Assessment [ ]  [ ]

 [ ] Autism [ ]  [ ]

 [ ] Asperger’s Syndrome [ ]  [ ]

 [ ] Functional Assessment [ ]  [ ]

Reason for referral to counseling:

Referring Person/Agency:

Phone Number:

Email:

Requested Services (Mark all that apply)