**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)