Alliance™ COUNSELING CENTER

THE CENTER AT HERON HILL

REFERRAL REQUEST

Today's Date: _____

Client's Name: _____ DOB: _____

Client Phone: _____ Insurance Carrier: _____

Name of Person submitting request: _____Phone:_____

Provider's Name: _____

Phone (if different than above): _____Fax: _____

Please include a copy of a Release of Information

Primary Mental Health Diagnosis: _____

First Appt/Admit Date_____ Discharge Date _____ Tx Ongoing ___

Are you a DHS Caseworker? _____

Service Reqst'd	***Recommended number of sessions per week/Add'l info***
_____ *Family Therapy*	_____
_____ *Individual Therapy*	_____
_____ *Group Therapy*	_____
_____ Day Treatment	_____

ADDITIONAL COMMENTS:

___

_____

_____

For follow up choose from the following options:

- ☐ **Weekly Updates** **Provider Contact info: (Phone)** _____
- ☐ **Update after each session**
- ☐ **Periodic at your discretion**
- ☐ **Include me in team meetings as needed**

FAX THIS REQUEST TO 503.263.6278