

CORE Professional Services, PA Treatment Referral Form

Client Name: _____
(first, middle initial, last)

Date of Referral: _____
DOB: _____
Client's Age: _____

Parent/Legal Guardian Name and Address (If minor or under guardianship):

Parent/Guardian Phone #: _____ Is Guardian attending appointment? ___ yes ___ no

Parent/Guardian email address: _____

Client Address: _____

Home Phone: _____ Cell Phone: _____

Other Phone: _____ (Belonging to _____)

Client's Email Address: _____

Referred By: _____ (phone)
Organization name: _____ (fax)
Address: _____ (email)

Referred For: Counseling/Psychotherapy Assessment/Evaluation (Type: _____)
 Group Therapy Cognitive Concerns

Payment Method: Client Insurance _____ (Insurance Information)
 County Pay _____ (County Name)
 Client responsibility (Cash Payment)

Former CORE Client? (if known) ___ yes ___ no. If yes which program? _____

Referral Information:

Social Service referrals

Written summary to include: Concerns, History of involvement with social services, previous evaluations, Items to be addressed in the evaluation

Documents to include: Referral Form Authorization for Release signed by client Chips Order/Court Order

Corrections/Probation referrals

Written summary to include: Questions/Concerns/Items to be addressed in the evaluation

Documents to include: Referral Form Authorization for Release signed by client Criminal Complaint Criminal History

Discharge Summaries from outside sex offender treatment programs Past Evaluations completed outside of this agency

Relevant information from a party outside of the referral source

Information Type: _____ Provided by: _____

Information Type: _____ Provided by: _____

Space below can be utilized for the referring parties written summary or a separate document can be provided:

Please allow 2-4 weeks for evaluation to be completed.