CLIENT NAME: _____ CREDIBLE ID# _____

CHESTNUT RIDGE
COUNSELING SERVICES, INC

SCHOOL BASED OUTPATIENT SERVICES
EXTERNAL REFERRAL

DATE OF REFERRAL: _____

NAME: _____ DOB: _____ GENDER: _____

PHONE #: _____

ADDRESS:
_____

SCHOOL: _____ GRADE: _____ IEP/504: Y / N

PARENT/GUARDIAN: _____

PERSON THAT HAS LEGAL RIGHTS TO CONSENT TO NON-ROUTINE MEDICAL TREATMENT:
_____
******COMPLETE FOR ALL CLIENTS UNDER THE AGE OF 14 AND OBTAIN LEGAL DOCUMENTATION

REFERRAL SOURCE: _____

REASON(S) FOR REFERRAL:
_____

_____

CURRENT MH TREATMENT: Y / N
TYPE OF SERVICE(S): _____

REFERRAL SOURCE DISCUSSED SCHOOL BASED SERVICES WITH PARENT / GUARDIAN / CLIENT: Y / N

DATE: _____ TIME: _____
**DISCUSSED WITH CLIENT FOR THOSE 14 AND OLDER

THERAPIST ASSIGNED: _____DATE: _____

REVIEWED BY PROGRAM MANAGER: _____ DATE: _____