Office: 575-249-2561
Fax: 575-541-3645
102 S Main St., Ste C, Carlsbad
5419 N Lovington Hwy, Ste 24, Hobbs
119 S Roselawn, Ste 300, Artesia
info@pbcg.org
www.pbcg.org

Referral Form

Date:________________**Reason for referral:** ____

Referral Source and Contact #: ____

Suicidal Ideation: ☐ Yes ☐ No **PHQ-9 Score for Question 9:** ______ **C-SRSS Score: Low Moderate High**

Is the client a current student or staff member of Artesia or Lake Arthur Public Schools? ☐ Yes ☐ No

Client's Name:______________________________________ **Phone:** _______________________

If client is a minor, Parent/Guardian name: ____

DOB:__________________________ ☐ **Male** ☐ **Female** ☐ **Other**___________________

Address:____**City:** ____________________________

Email address: ____

Insurance: ☐ Yes ☐ No **Type of Insurance:** ____

Services Requested For:

☐ Abuse
  ☐ Emotional ☐ Sexual ☐ Physical ☐Verbal
☐ ADHD
☐ Anger
☐ Anxiety / Panic
☐ Behavioral Problems
☐ Bipolar Disorder
☐ Career Counseling
☐ Couples Counseling / Relationship Issues
☐ Depression
☐ Domestic / Family Violence
☐ Family Counseling
☐ Grief / Loss
☐ Health / Pain Issues
☐ Insomnia
☐ Play Therapy
☐ Psychosis
☐ PTSD
☐ Sexual Orientation / Gender Identity
☐ Sexual Assault
☐ Substance use issues
☐ Suicidal Ideation
☐ Survivors of Suicide Support Group
  (for those who have lost a loved one to suicide)
☐ Trauma
☐ Veteran / Family Program (anyone who has served in the military and eligible dependents)
☐ Weight Loss
☐ Other: ___________________________________

Specific Therapist Request:

☐ No preference ☐ Spanish Speaking ☐ Telecounseling Only ☐ Case Management

☐ Other____

Comments ____

Date Received:________________**Date Called:**________________**Who Made Contact:** _______________________

Appointment Made: ☐ **Y** ☐ **N** **If No, Reason:** ____