PERMIAN BASIN COUNSELING & GUIDANCE

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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 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:

- ☐ ADHD
- ☐ Anger
- ☐ Anxiety / Panic
- ☐ Art Therapy
- ☐ Autism Assessments
- ☐ Behavioral Problems
- ☐ Bipolar disorder
- ☐ Career Counseling
- ☐ Cognitive Behavioral Therapy for Insomnia
- ☐ Cognitive Behavioral Therapy for Weight loss
- ☐ Couples Counseling / Relationship Issues
- ☐ Depression
- ☐ Domestic / Family Violence
- ☐ Family counseling
- ☐ Grief/Loss
- ☐ Group therapy
- ☐ Health/Pain issues
- ☐ Play Therapy with Registered Play Therapist
- ☐ Psychological Testing/Evaluations
- ☐ Psychosis
- ☐ PTSD/Abuse/Trauma/Rape
- ☐ Sexual Orientation/Gender Identity/other issues
- ☐ Substance use issues
- ☐ Suicidal Ideation
- ☐ Survivors of Suicide Support Group (for those who have lost a loved one to suicide)
- ☐ Veteran/Family Program (anyone who has ever been in the military or their family is eligible)
- ☐ 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:** _____