A logo for a therapy session

Description automatically generated

**Psychotherapy/Psychoeducation Referral**

|  |  |  |  |
| --- | --- | --- | --- |
| **Service Facilitator Information** | | | |
| SF Name: |  | Agency: |  |
| SF Phone: |  | Date: | 3/28/2024 |
| SF Email: |  | | |

|  |  |
| --- | --- |
| **Client Information** | |
| Client Legal Name:  (& preferred name if different) |  |
| Guardian Name:  (& relationship to client) |  |
| Pronouns: |  |
| CCS Module Number: |  |
| Date of Birth: |  |
| Phone Number: |  |
| Email: |  |

|  |  |
| --- | --- |
| **Psychotherapy/Psychoeducation Information** | |
| Mental Health Diagnosis: |  |
| Physical Health Diagnosis:  (includes chronic pain concerns) |  |
| Substances Used: |  |
| Medication List: |  |
| Prior Hospitalizations: |  |
| Currently Suicidal: |  |
| Disability Accomodations: |  |
| Psychotherapy Goals:  (please indicate if client is seeking individual psychotherapy, dance therapy, or family therapy/psychoeducation) |  |
| Comments/Preferences: |  |

|  |  |
| --- | --- |
| **Other CCS Services** | |
| Psych Prescriber: |  |
| Other Services Providers: |  |

**\*\*\* Please email completed form to** [**abigail@insightmadison.com**](mailto:abigail@insightmadison.com) **\*\*\***