

**Psychotherapy/Psychoeducation Referral**

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

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

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| **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: |  |

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

**\*\*\* Please email completed form to** **abigail@insightmadison.com** **\*\*\***