The Practice Counseling Services, Licensed Clinical Social Worker Prof. Corp.
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THE PRACTICE COUNSELING SERVICE REFERRAL

1. Please complete the information below.
2. The client or guardian MUST sign and date stating that they agree to the referral OR indicate how verbal permission was received.
3. Return the completed application by **Fax to (707) 419-4673**

CLIENT INFORMATION

First Name		Last Name		Preferred Language	
Birth Date		Sex		School/Grade Level	
Address				Telephone	
Okay to leave a message? Yes☐ No☐		Alternate Telephone		E-mail	
Medical Insurance				Social Security #	
Parent Name		Parent Preferred Language		Parent Telephone	

REFERRING PARTY INFORMATION

Agency Name		Phone	
Staff Name		Fax	
E-Mail			

REASON FOR THE REFERRAL: (If in imminent risk please contact Solano County Crisis at 707-428-1131)

__________________________________ ____________________

Client/Guardian Signature **Date**

****Client authorizes request for services and discussion of referral status with referring party.**

HOW DID YOU HEAR ABOUT THE PRACTICE COUNSELING SERVICES?

☐ Word of mouth ☐ I’m a former client ☐ Psychology Today ☐ Referral ☐ Community Partner: ______________