The Practice Counseling Services, Licensed Clinical Social Worker, Prof. Corp.
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PCS Request for Services

Guidelines for Request of Mental Health Services

1. Please complete the information below
2. Client or Guardian **MUST** sign and date indicating their agreement for you to request Mental Health Services on their behalf.
3. Return the completed form by **Fax** at **(707) 419-4673** or **Emai**l to the form to **Clinicians@thepracticecs.com**

CLIENT INFORMATION:

Name: _____ DOB: _____ Phone: _____

Can we leave messages: Y_____ N_____

Guardian/Parent Name:_____

Address: _____ City: _____ Zip: _____

SSN#: _____ Type of Insurance: _____

Preferred Language: _____

Client Signature: _____ Date: _____
* Client authorizes request for services and discussion of referral status with referring party.

Guardian Signature: _____ Date: _____
* Required for minor aged clients.

REFERRED BY:

Name: _____ Phone: _____ Date of Referral: _____

Address: _____ City: _____ Zip: _____

Agency: _____ Email: _____ Fax: _____

Is this client in a crisis? □ YES □ NO

Comments: _____
_____
_____
_____
_____
_____