



1759 West Broadway St, Suite 3
Oviedo, FL 32765
Phone: 407-977-4335 Fax: 407-977-4370
www.resiliencecc.com

REFERRAL FOR COUNSELING SERVICES

Date _____

Client's First Name _____ Last Name _____ MI _____

Name of Parent/Guardian if applicable _____

Address _____ City _____ State _____ Zip _____

Telephone (Home) _____ (Cell) _____

E-mail: _____

Birth date ____/____/____ Gender __F__M

Insurance Plan: _____ Policy #: _____

Reason for Referral:

- | | | | |
|--|--|--|---|
| <input type="checkbox"/> Anxiety | <input type="checkbox"/> Depression | <input type="checkbox"/> Inattentiveness | <input type="checkbox"/> Impulse Control |
| <input type="checkbox"/> Panic Attacks | <input type="checkbox"/> Self Mutilation | <input type="checkbox"/> Social Skills | <input type="checkbox"/> Anger Management |
| <input type="checkbox"/> Noncompliance | <input type="checkbox"/> PTSD Symptoms | <input type="checkbox"/> OCD Symptoms | <input type="checkbox"/> Phobia _____ |
| <input type="checkbox"/> Eating Disorder | <input type="checkbox"/> Legal | <input type="checkbox"/> Sexual Issues | <input type="checkbox"/> Separation /Loss |
| <input type="checkbox"/> Self-esteem | <input type="checkbox"/> Substance Abuse | <input type="checkbox"/> Family conflict | <input type="checkbox"/> Hallucinations |
| <input type="checkbox"/> Sleep Issues | <input type="checkbox"/> Nervousness/Tension | <input type="checkbox"/> Relationship Issues | <input type="checkbox"/> _____ |

Has the client been made aware of the referral to Resilience Counseling Center, Inc.? _____

Is a Release of Information form attached so that we may inform you of the outcome of the referral? _____

Referred by:

Signature _____ Date _____

Printed Name and Title _____ Agency Name _____

Phone: _____ Fax: _____

E-mail: _____

Please fax this form to 407-977-4370 or e-mail it to info@resiliencecc.com