Center for Trauma Counseling, Inc.
6801 Lake Worth Road, Suite 307
Greenacres, Florida 33467
561-444-3914 office 561-768-7719 fax
www.palmbeachmentalhealth.org

INTERAGENCY REFERRAL FORM

Referrer Information: **PLEASE FAX THIS FORM TO (561) 768-7719**

Date of Referral: _______________

Referral Source: ____

Last Name: ____________________________________ **First Name:** _________________________________

Phone No.: ______________________ **Cell:** ________________________ **E-mail:** ___________________________

Client Information:

☐ **Individual Session** ☐ **Family Session**

Name: ____

D.O.B. _______________________________ **Gender of Client:** _____________

Total Number of people to be in session: ___________________ **Ethnicity:** ☐ **Black** ☐ **Caucasian** ☐ **Hispanic** ☐ **Other**

Address: ____

Home Phone No.: _______________________ **Cell:** ___________________________ **E-mail:** ___________________

Name of Legal Guardian: ________________________ **Phone No. of Legal Guardian:** _______________________

Name of Case Manager (If Applicable): _________________ **Child's School (If Applicable):** __________________

Briefly Describe Chief Complaint/Issue/Reason for Referral:

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Insurance Information:

Is client insured: ☐ **Yes, type of insurance:** ____ ☐ **No**

If not insured: ☐ **Self Pay** ☐ **Sliding Scale**

If sliding scale is requested, please complete the following:

Yearly income: ________________________________ **Number of Dependents:** ______________________

Please note that sliding scale services are for low income clients and is based on federal poverty guidelines. Clients must qualify for sliding scale services

HIPAA Privacy Notice – Do Not Submit via Email
To protect your privacy and comply with HIPAA regulations, please DO NOT submit this form via email, as email is not a secure method of transmitting protected health information (PHI).