



Healing Transitions Creative Counseling for Children & Families Inc.

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Click on the Line at the end of the text Inside Each Text Box to Complete Form Online
Double Click on the Desired Small Auto Boxes to Shade Them Black

Date: _____ New Reopen Referral Taken By: _____

Individual Making Referral:	Relationship to Client: _____
Name: _____	Phone: _____ Fax: _____
(Email Address): _____	

CLIENT:	(First Name): _____	(MI): _____	(Last Name): _____
	(DOB): _____	(SSN): _____	(Gender): _____
(Street Address): _____	(City): _____	(State): _____	(Zip Code): _____
(Home Phone): _____	(Cell): _____	(Work): _____	
(Email Address): _____			

LEGAL GUARDIAN:	(Relationship to Client): _____
(First Name): _____	(Last Name): _____ (Phone): _____
Caregiver Name (If Different from Legal Guardian):	(Relationship to Client): _____
(First Name): _____	(Last Name): _____ (Phone): _____

(Insurance / Copay): _____	(Member ID or Policy #): _____
Primary Insured: _____	(DOB): _____ (SSN): _____

(REASON FOR REFERRAL): _____

- Individual Therapy Play Therapy Family Therapy
 Couples Therapy Group Therapy EMDR Domestic Violence
 Parenting Class Therapeutic Visitation (Other): _____

Please FAX Completed Referral Forms to (941) 842-1012