



Life & Work Solutions
healing for your mind & soul

Fax to **888.216.6045**

Referral Form for Behavioral Health Treatment Services

Date: _____ Referring Person: _____

Referring Agency: _____ Email: _____

Phone No: () _____ - _____ Fax No: () _____ - _____

Do you have a release signed by the client to communicate with **Life & Work Solutions**? _____

If so, please attach. If not, we will not be able to share info without a signed consensual release.

Client's Name: _____ Gender: M F Age: _____

Date of Birth: ___ / ___ / ___ Social Security Number: ___ - ___ - ___ Marital Status: _____

Address: _____ City: _____ State: ___ Zip: _____

Best Contact Number: () _____ - _____ Email: _____

Secondary Contact Number: () _____ - _____ Funding/Insurance: _____

Primary Caregiver if Client is a Minor: _____

Date of Birth: ___ / ___ / ___ Social Security Number: ___ - ___ - ___ Marital Status: _____

Services Requested: Individual/Couples/Family Counseling Case Management

Mental Health Eval Substance Abuse Eval Other: _____

Presenting Problem(s): _____

Name of all people living with the client	Date of Birth	Gender	Relation to Client
1			
2			
3			
4			
5			