Creative Counseling & Learning Solutions, PLLC
PO Box 81 Badin, NC 28009 704-422-5964(office) / 704-422-5041(fax)
www.creativecounselingandlearningsolutions.com

Referral for Counseling Services

Client's name: ______________________________ Birthday: ____/_____/_______ SS#:______________________
Phone#: ____________________ Alternate Phone#: ___________________ Parent name: ________________________
Address: ____ School: ____________________________

Insurance: ___ NC Medicaid (County ____________) ___ NC Healthchoice ___ Private Insurance (Type ____________)
___ None Insurance Policy# ____________________________ (If possible, please send a copy of the insurance card with this referral form)

Referral source (name of individual providing referral info): ___ School: ________________ ___ Doctor: ________________
___ DSS: ____________________ ____ Other: __________________________ Contact info: ____________________

Signature of referral source: ____ Date: ______________

Concerns/Needs to be addressed in therapy: (Please check all that apply and explain below with as much info as possible):

___ Abuse/neglect
___ Aggression
___ Argumentative
___ Anxiety
___ Alcohol/drug use
___ Academic problems
___ Bullying concerns
___ Cries easily
___ Difficulty focusing
___ Danger to self/others
___ DSS/legal involvement
___ Divorce/separation issues
___ Depressed mood
___ Destructive
___ Fights w/ others
___ Grief/loss
___ Hyperactivity
___ Hallucinations
___ Kinship/foster placement
___ Oppositional/defiant
___ Panic Symptoms
___ Parenting issues
___ Relationship concerns
___ Recent trauma
___ Truancy
___ Suicidal concern
___ Self-esteem concerns
___ Social issues
___ Suspension/expulsion
___ Self-harming behaviors
___ Sexualized behaviors
___ Sleep/eating concerns
___ Toileting concerns

Summary of problem(s)/Presenting concerns:

Services requested (select as many services as you feel may benefit client): ___ Unsure ___ Clinical Evaluation ___ Crisis Eval.
___ Individual therapy ___ Group therapy ___ Family therapy ___ Play therapy ___ CBT ___ TFCBT ___ PCIT (ages 3-6)
___ Equine-assisted therapy (ground-based w/ horses) ___ DBT ___ Parenting classes ___ Other: ____________________

Preferences:
Location: ___ In home ___ At school/daycare: ______________________ ___ New London office/barn
___ Norwood barn location ___ Cabarrus office ___ Cabarrus barn ___ Other (list here) ____________________
Time & Day: ___ Mornings ___ Afternoons ___ Evenings ___ Mon ___ Tue ___Wed ___ Thur ___ Fri ___ Sat
Comments about preferences: ____
Other preferences: ____

**** Fax completed referral form, along with your contact information, to our office to complete the referral ****

For office use only

Date of contact	Time of contact	Results	Clinical Assessment (CCA)Scheduled	Date CCA Completed

Date referral source contacted ____________ Time ____________ Results ______________________________
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