lifespan counseling

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LIFESPAN COUNSELING OMAHA REFERRAL FORM

This form is to be completed by the Referrer/Agency Department

THIS FORM IS CONFIDENTIAL and must be agreed by the client that the details set out on this referral form are accurate.

Please print form. Fill out and fax or email on number or email indicated above.

A confirmation email of acknowledgement will be sent to the referrer.

Name of Client: _____

Address of Client: _____

Telephone of Client: _____

Date of Birth: _____ / _____ / _____

Gender: Male ☐ Female ☐

Services Needed: Group Therapy ☐ Individual Therapy ☐

Name of the organization referring: _____

Address and phone number of referring organization_____

Name of the person referring behalf of the organization: _____

Date of Referral _____/ _____ /_____

Issues identified

_____

Are there any other areas of concern that require support? Risk factors?

Details of GP

Name of GP _____

Practice name and address _____

GP Contact no. _____

Does the referred client require follow up by Lifespan Counseling Omaha to be assisted with the referral process (gaining a mental health care plan etc.)?

Yes ☐ No ☐

Has a Mental Health Care Plan already been obtained from the GP? (for non-contracted services)

Yes ☐ No ☐

Does the referrer need to be notified of the outcome (pending client permission)?

Yes ☐ No ☐

If yes, please provide an email address of referrer_____

Thank you for your referral.

Lifespan Counseling Omaha is a mental health agency committed to serving clients across the Lifespan. Please do not hesitate to contact our facility should you require any further information or assistance.

Kind regards