THE COUNSELING CENTER

1900 E. 10TH STREET ALAMOGORDO, NEW MEXICO 88310
Phone (575) 488-2500 • Fax (575) 488-2502

Client Referral for Services

Client's Name: _____ Date of Referral: _____

Date of Birth: _____ Social Security Number: _____

Address: _____

Phone Number: _____ Email: _____

Other community or school services the client receives (e.g. JPO, APO, JCCP):

Client's Primary Care Provider: _____

List of medications the client is taking and the provider that prescribes them:

Client Insurance: _____

Presenting problems:

Client needs to be seen within: ☐ 24 hours ☐ 48 hours ☐ one week

Referred to: _____ for _____

Referred by: _____ Phone Number _____

Relationship to Client: _____

Note: This section must only be completed for clients under 18 years of age.

Parent/Guardian Name: _____

Is the parent or guardian aware of this referral? ☐ Yes ☐ No

Who has legal custody of the client? _____