EveryMind.
Your mental wellness.
Our mission.

Referral Form

Date: _____

CLIENT INFORMATION

Name: _____

Date of Birth: _____ Gender: _____ Marital Status: _____

If under 18, name of parent/guardian: _____

Home Address: _____

_____

Home Phone: _____ Cell Phone: _____

Best Time to Call: ☐ morning ☐ afternoon ☐ evening Best Number to Use: ☐ Home ☐ Cell

Is it okay to leave a message on your voicemail? ☐ Yes ☐ No

Email Address: _____

Other Language Spoken: _____ Preferred Language: _____

Do you have health insurance? ☐ Yes ☐ No Medicaid? ☐ Yes ☐ No

Country of Origin: _____ Years/Months in U.S. _____ Yrs. _____ Mos.

REFERRAL SOURCE

Name of Referral Source: _____ Relationship to Client: _____

Organization Name: _____ Phone Number: _____

Email Address: _____

Is client aware referral to EveryMind has been made? ☐ Yes ☐ No

SERVICES REQUESTED:

☐ Individual Counseling ☐ Case Management ☐ Friendly Visitor
☐ Family Counseling ☐ Serving Together ☐ Representative Payee

Reason for Referral/Presenting Problem:
