EveryMind.
Your mental wellness.
Our mission.

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Referral Form

Client Information

Name: ______________________________ Date: ______________

Date of Birth: __________ Gender: ____ School (if applicable): ______________

If under 18, name of parent/guardian: ______________________________

Home Address: ______________________________

____

Best Phone Number to Reach You: ______________________

Best Time to Call: ☐ Morning ☐ Afternoon ☐ Evening Is it okay to leave a message? ☐ Yes ☐ No

Preferred Language: ______________ Other Language Spoken: ______________

Do you have Medicaid? ☐ Yes ☐ No Do you have Medicare? ☐ Yes ☐ No

Do you have any other insurance? If yes, what type? ______________________

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

☐ Counseling: Adult Youth Family
☐ Homeless Outreach - Case management for street homeless individuals
☐ Friendly Visitor – Volunteer-based visits to homebound older adults (65 or older)
☐ Youth Case Management – Services for youth at risk for or involved with the juvenile justice system
☐ Representative Payee – Volunteer-based support for SSI/SSDI recipients
☐ Serving Together – Information and referral for veterans and their families

Reason for Referral/Presenting Problem: