Connective Healing, LLC

one seed of hope at a time

Referral Form

Client Information

Name:	Date of Birth:	Race/Ethnicity:
Gender: ❒ Male ❒ Female ❒ Couple	School & Grade (if youth):	
Services Requested: ❒ Individual Counseling ❒ Family Counseling		
CONTACT NUMBERS:	Message ok? ❒ Yes ❒ No	
ADDRESS:		

Parent, Legal Guardian Information (if applicable for youth or adult):

Name of Parent or Legal Guardian:	Address:
Contact Numbers:	Relationship to referred client:

Referral Source Information: Complete this section so we can contact you after the referral is made.

Name	Mailing Address
Phone#	Email address
Relationship to client referred?	
How did you hear about Connective Healing LLC?	

Child/Adult Health Information (if obtainable within your role to client):

Current medication & dosage?
Current DSM-V Diagnosis, if known?
Is client receiving counseling or have they received past counseling services? Who is/was their provider?
Prescribing Physician name & Phone?
Any additional comments/ concerns about client mental health or physical health that may be relevant to treatment?

Connective Healing, LLC
101 N Main St Stanton KY 40380
Owner/ Provider: Lisa C. Coffey, LCSW

Individual & Family Counseling Ph: 859-230-5957
Email: connectivehealingllc@gmail.com
Website: connectivehealingllc.com

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Current Mental Health Symptoms:	Unknown	Not Present	Mild	Moderate	Severe
Hallucinations (describe)					
Delusions					
Thought disorder					
Bizarre (psychotic) behavior (describe below)					
Anxiety / Nervousness					
Obsessive / compulsive					
Phobias / fears					
Depressed mood					
Mood swings					
Sleep disturbance					
Irritability					
Anger / temper tantrums					
Hyperactivity					
Attention deficit					
Eating problems					
Elimination problems					
Oppositional / defiant to those in authority					
Antisocial / delinquent behavior / conduct disorder					
Over sexualized behavior					
Somatic complaints with no known medical cause					
Attachment disorder (explain below)					
Substance Abuse/ Dependence issues					
Other (explain)					

Reason for referral for treatment: In your own words, describe the reason for the referral of this child/adult (i.e. Why are they in need of mental health services). Please describe specific behaviors the child/adult is exhibiting, which create concern for their well being or daily life functioning.

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*****Please advise client to bring insurance or payment information to first session. Please scan and email to my office email. Thank you for entrusting me with the mental health care of the referred party!**

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