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Aspentree Counseling & Hypnotherapy
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Referral for Services

Today's Date: _____

Referral of Client
Name: _____ DOB:_____
Address: _____
Phone(s): _____ Email:_____
*Program involved with (residential, employment, school, other):*_____
Contact Person (s):_____ Phone: _____
Email: _____

Referring Person
Name: _____ Agency: _____
Phone: _____ Best time to contact:_____
Email:_____

Request:
___ Psychotherapy ___Hypnotherapy ___IP/DDA Respite Care ___IP In-Home Nursing Care

___DDA Counseling Services ___DDA Behavioral Specialist Svc's ___DDA Behavior Technician Svc's

___ OTHER (Specify):_____

Reason(s) for Referral (*please include when issues became known and date last occurred, location and any other pertinent information*)
_____
_____
_____
_____
Greatest Concern: _____
Any relevant medical concerns, diagnosis or other issues:
_____
_____

Attach any supporting documents and completed Release of Information
For DDA Contracted Services, please submit: 1) this referral. 2) Signed Approval. 3) ISP.

<u>Section for AC&H Office Use Only</u>
Approval of referral: YES NO (reason):_____
_____.