FHN Family Counseling Center Consultation and Referral Form

421 W. Exchange St., Freeport, IL 61032	300 Summit St., Galena, Illinois 61036
Phone: 815-599-7300 Fax: 815-599-7398	Phone: 815-777-2836 Fax: 815-777-2849

Referrer Information (*indicate preferred mode of contact below*)	**Client Information**
Date of Referral:	Client Name:
Referrer Name:	Date of Birth:
Referrer Agency:	Address:
Address:	
	Phone Number:
☐Phone:	Parent/Guardian:
☐Secure Fax:	Insurance Information:
☐Secure Email:	

Purpose of Referral:

☐Psychiatric Services ☐Assessment Only ☐ Therapy (Individual/Group/Family)
☐Court Ordered (must include copy of court order) ☐ Other: ___________________________

Services Requested:

☐ Transfer complete care of presenting problem
☐ Consult for recommendation only for presenting problem
☐ Consultation for recommendation and treatment for presenting problem
☐ Ongoing, collaborative treatment of patient
☐ Other: ____

Authorization for Release of Information Signed? (*please attach if signed*) ☐ Yes ☐No

Response to Referral Requested? *(Must be checked to receive feedback regarding referral)* ☐ Yes ☐No

Presenting Problem: (*check all that apply & attach assessments or additional information regarding symptoms*)

☐ Depression ☐ Anxiety ☐ Bipolar ☐ Schizophrenia
☐ Marriage/Couples ☐ ADHD ☐ PTSD/Trauma ☐ Behavior Problems: Specify: ___________
☐ Anger Management ☐ Hallucinations ☐ Delusional Thoughts ☐ History of Psychiatric Hospitalization
☐ Self-Injurious Behavior ☐Suicidal Behavior ☐ Bizarre Behavior ☐ Manic Behavior/Speech; Racing Thought
☐ Other: (please specify) ____

Additional Information: ____

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Information requested from FHN FCC by Referrer: (*Must be specified on release of information form*)

☐ Assessment/Diagnosis ☐Treatment Recommendations/Treatment Plan/Frequency
☐ Medication List/Medication Changes ☐Treatment Attendance/Compliance
☐ Psychiatric Progress Notes/Progress Report ☐Other: _________________________

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Referrer Signature **Date**