Date Received by Discovery Counseling: ____________

820 Ebenezer Church Rd. Suite 110 Sharpsburg, GA 30277

420 Thomaston St. Zebulon, GA 30295

Phone: (404) 960-1282 Fax: (855) 817-2428

REFERRAL FORM

Date: ___________ Service Needed ______________________ Status: Urgent or Regular

REFERRAL SOURCE

First Name: _________________________ Last Name: ______________________________

Phone: ___________________ Fax: _____________________

Agency: ____

Email: __________________________________

CLIENT INFORMATION

First Name: _________________________ Last Name: _______________________________

D.O.B. __________________ Social Security #: _____________________ Male Female

Insurance Name & Number: ____

Street Address: ______________________________________ Apartment/Unit #: __________

City: ____________________________ State: ___________________ Zip Code: ___________

Home #: ___________________ Cell #: ___________________ Work #: ___________________

CAREGIVER #1 INFORMATION

First Name: _________________________ Last Name: ________________________________

D.O.B. __________________ Relationship to Child: ___________________________________

Street Address: ______________________________________ Apartment/Unit #: __________

City: ____________________________ State: ___________________ Zip Code: ___________

Home #: ___________________ Cell #: ___________________ Work #: ___________________

CAREGIVER #2 INFORMATION

First Name: _________________________ Last Name: ________________________________

D.O.B. __________________ Relationship to Child: ___________________________________

Street Address: ______________________________________ Apartment/Unit #: __________

City: ____________________________ State: ___________________ Zip Code: ___________

Home #: ___________________ Cell #: ___________________ Work #: ___________________

____

Do the caregivers have full custodial rights to make medical and educational decisions for this child? ***YES*** ***NO***

Is there another parent or caregiver with joint custody we should inform about treatment? ***YES*** ***NO***

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REASON FOR REFERRAL/COMMENTS:

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Date Received by Discovery Counseling: ____________

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