Peace In Mind Counseling, LLC
THE BREATH BETWEEN EVERY STEP

Name of referring provider: _____ Date of Referral _____

Phone number of referring provider: _____ Email of referring _____

Client name	DOB	Client address	Phone Number
Parent Name (if applicable)	**DOB**	**Parent address**	**Phone Number**

☐ PCP name _____Fax _____ Phone_____

☐ School Name _____ Fax _____ Phone _____

☐ Other Referral _____ Fax _____Phone _____

Reason for referral:

☐ Family IHT (17 years old or younger) – assessment for this LOC will be necessary

☐ Individual Counseling for the child

☐ Family Counseling – in office

☐ Parent seeking counseling services

☐ General Referral

Please follow up:

☐ ASAP/Urgent referral

☐ No later than two weeks

☐ At earliest convenience

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