



Mary Lee's House Therapy Referral Form

Referral Date: _____

Program(s) Receiving Referral (check box):

- | | |
|---|--|
| ☐ Trauma Therapy | ☐ Speech Therapy |
| ☐ Behavioral Therapy | ☐ Support Group |
| ☐ Family Therapy | ☐ Sibling Therapy |
| ☐ Other _____ | |

Client Demographics

First Name	Last Name	Date of Birth	Age
Address: _____			
Phone Number: _____		County: _____	
Gender: _____	Race: _____	Ethnicity: _____	
Primary Language: _____		Email Address: _____	

Complete for Referral of Minor

Parent/Guardian Name: _____	☐ Parent ☐ Guardian
Parent/Guardian Phone Number: _____	

Client Information

Client Disability? ☐ Yes ☐ No ☐ Do Not Disclose	Accommodation needed: _____
Is the client aware the referral is being made? ☐ Yes ☐ No ☐ Unknown	Does the client have insurance? ☐ Yes ☐ No Name of insurance? _____

Would you like the Voices for Children Service Dog available for therapy? _____

Referral Information

Name of Referral Source: _____	
Title: _____	
Agency: _____	Preferred Contact Method: ☐ Phone ☐ Email
Phone Number: _____	Email Address: _____

Reason for Referral:

Please provide detailed reason for referral and the clients desired services

Preferred days and times for counseling: