**Referral for Therapy Services**

**Date of Referral:** **Referring Agency:**

**Phone: Name:**

**Child’s Name**: **DOB**:

**Guardian’s Name**:

**Contact Information**

**Has the child been seen for Forensic Interview Yes** ☐ **No** ☐ **If yes, when** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Brief description of the presenting issue**: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Previous therapeutic interventions:**

**Other current services:**

**Funding Available** **Yes** ☐ **No** ☐ If yes, type of funding \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Additional Information/Comments:**