**Atlas Counseling Center, Inc**

174 Costello Drive, Winchester, VA 22602

Phone 540-722-6238; Fax 540-662-5536

**REFERRAL FORM [ ]  New Client [ ]  Returning Client Date:**

Client Name: *First**MI**Last*Date of birth:

SSN *(last 4 digits)*:Gender: [ ]  M [ ]  F Marital Status: [ ]  Single [ ]  Married [ ]  Divorced

Physical Street Address: Suite/Apt#:

City: State:Zip+4:

Mailing Address (*if different than above*):

City: State: Zip+4:

Home Phone: Cell Phone:\_ Work Phone:

Please check the preferred method of contact: [ ]  Home phone [ ]  Cell phone [ ]  Email: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Employer or Name of School: Highest or Current Grade:

Occupation: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Ethnicity:  Preferred language:

Funding Type (Insurance, Self-Pay, FAPT, Other):  Insurance Carrier/Primary:

**Who should we contact regarding this referral?** [ ]  **Client** [ ]   **Parent/Guardian (*enter contact information below*)**

**May we leave a message? [ ]  No [ ]  Yes, on (*check all that apply*) [ ]  Home phone [ ]  Cell Phone**

**Is the client or parent/guardian aware of and agreeable to this referral? [ ]  Yes [ ]  No**

**Parent/Guardian Contact Information (for minors only)**

[ ]  Parent(s) [ ]  Foster Parent(s) [ ]  Legal Guardian

Name(*s*):

Street Address (*if different than client*):

City: State: Zip+4:

Home Phone: Cell Phone: Work Phone:

**Requested Service**

[ ]  Substance Use Assessment (ASAM) [ ]  Substance Use Treatment [ ]  Mental Health Evaluation and/or Treatment

 [ ]  SUD Group (Prevention, OP, IOP) [ ]  Other:

**Reason for Referral/Presenting Needs**

Describe:

Any current or previous Diagnosis(es)? [ ]  No [ ]  Yes, please list:

Currently participating in any other treatments? [ ]  No [ ]  Yes, please list the type of treatment and provider name:

Describe current living arrangements:

**Referred By *(if applicable)*** [ ]  Self-referral

Agency/School Name: Contact Name:

Phone: Fax:  Email: