An In-Home Family Therapy Program

Referral Form

**Referral cannot be processed without all insurance information included

Referral Date _____

Demographic Information

Client Name			
Address		*Phone Number*	
Email		*Date of Birth*	
Insurance Name & ID#		*If Commercial Ins. Name and DOB of Policyholder*	

PLEASE NOTE

*Insurance information and dates of birth for all family members **MUST** be included to process referral.*

Please list family members starting with the oldest

Name of Family Member	*DOB*	*Insurance ID #*	*Relationship to Client*

Current/Past Services

Name of Client	*Program*	*Agency*

Type of Service: Please check all that apply

- o In-Home **ONLY**
- o Tele-health Virtual **ONLY**
- o Open to Hybrid of In-Home and/or Virtual
- o Open to Telehealth if In-Home is not available

Is the client interested in services in-home or through telehealth? **Yes** ☐ **No** ☐

Is this client able to have services virtually via telehealth if in-home is not available in their area? **Yes** ☐ **No** ☐

Reason for Referral

Are there any safety concerns?

Are there any pets in the house?

Are there any additional concerns that should be noted prior to intake (such as parking, outdoor animals, entrance codes, etc)?

Referral Source Information

Name		*Agency*	
Office Ph		*Cell Ph*	
Email			

Please send referral to

Courtney DeLauri, Director of Community Based Programs

Email: courtney@stokescounseling.com

Fax: 203-632-5190

Questions? Call 203-729-0341