THE COUNSELING SOURCE, INC.

10921 REED HARTMAN HIGHWAY, SUITE 133
CINCINNATI, OH 45242
Phone: (513) 984-9838 * FAX (513) 984-8075
800-618-0688 800-738-9854

FAX REFERRAL SHEET/ PHONE INTAKE FORM
PLEASE USE BLACK INK AND PRINT CLEARLY

REFERRAL DATE: _____ Grade:_____ HR Teacher:_____

_____ ROUTINE: Appointment scheduled within 2 weeks
_____ PRIORITY: Appointment scheduled within 1 week, Serious symptomology displayed
_____ URGENT*: Appointment scheduled same day as referral, danger to self or others, treat as an emergency.
*If referral is urgent, call The Counseling Source office to notify in addition to sending fax referral.

(Please Note: Appointment is subject to contact with parent/guardian, their availability and/or willingness to consent to treatment of child)

*Child/STUDENT NAME: _____ ☐Male ☐Female

*ADDRESS: _____

*CITY: _____ *STATE:_____ *ZIP:_____

*PHONE NUMBER OF CLIENT: _____ *SCHOOLBUILDING:_____

*CLIENT DATE OF BIRTH:_____ SOCIAL SECURITY #:_____

*Parent/Guardian (Relationship to Child):_____

*PHONE NUMBER(S): _____

ADDRESS: · Same as Client or _____

CITY: _____ STATE:_____ ZIP:_____

*Has Parent/Guardian Been Notified: ☐Yes ☐No Misc. Notes:_____

Child Medicaid: _____ Medical Card # (12 Digits): _____

*PRESENTING PROBLEM(s) (Circle all that apply):

1. suicidal thoughts/statements/attempts	6. appetite problems	11. emotional outbursts	16. problem behaviors
2. acting sexually inappropriate	7. being depressed	12. impulsivity	17. psychotic thinking
3. adjustment difficulties	8. being withdrawn	13. inattention	18. relationship problems
4. anger problems	9. changes in sleep patterns	14. memory problems	19. thought distortion
5. anxiety	10. fears	15. mood swings	20. worries

21. other:_____

*NAME and TITLE OF PERSON MAKING REFERRAL:_____

*PHONE NUMBER/CONTACT INFO: _____

(*Note: Marked fields indicate information required by the referring party)

FOR OFFICE USE ONLY:

Referral Received:_____

Primary Clinician:_____ Admit Date:_____

· Previously seen by TCS