Referral for Therapeutic Counseling

Fax Form: 706-928-5183
Family Resource Center Phone: 706-778-3100
Referred By: _____

Email Form: referrals@pcahabersham.org
Date of Referral: _____
Referring Agent Phone: _____

Referral Name: _____

Are they or have they been enrolled in services with Prevent Child Abuse Habersham? Yes ☐ No ☐
If yes, what program? _____ Date Exited Services: _____
Were they ever convicted of a crime against a child? _____.

DOB: _____ Age: _____ Race: _____ Gender: _____ Ethnicity-Hispanic? Yes or No

Parent/Guardian: _____Relationship: _____

Address: _____ County: _____

Contact Number: Cell: _____ Home: _____ Work: _____

Insurance Coverage: _____ Annual Household Income: _____

Victimization (Form of Adverse Childhood Experience) Please check all that apply:

CHILD – incident occurred in last 5 years				ADULT – incident occurred in childhood			
Parents Divorced/Separated	☐	Bullying	☐	Parents Divorced/Separated	☐	Bullying	☐
Abandonment	☐	Pornography	☐	Abandonment	☐	Pornography	☐
Parental Substance Abuse	☐	Parent Mental Health	☐	Parental Substance Abuse	☐	Parent Mental Health	☐
Traumatic Grief	☐	Incarcerated Parent	☐	Traumatic Grief	☐	Incarcerated Parent	☐
Other:				Other:			

Current Counseling Services: _____ Past Counseling Services: _____

DFCS Contact: _____ Number: _____

Law Enforcement Contact: _____ Number: _____

INTERNAL USE DO NOT COMPLETE

Date Referral Received: _____ Contact with Client (Date): _____
Contact Notes:

PCAH Client #: _____Referral Outcome: ☐Assessment Scheduled ☐ Set First Appointment
Assigned Therapist: _____

Assessment Outcome: _____
Contact with Client (Date): _____

Treatment Outcome			
Client Completed Treatment	☐	Partially Completed Treatment: Why exit?	
Exit Survey Completed	☐	Date Exited Program:	No. of sessions used: