PROVIDER REFERRAL FORM FOR TRAUMA SERVICES

Download form to send to ticcreferrals@gmail.com

TICC Trauma Informed Counseling Center
WHERE COUNSELING COMES FIRST

REFERRAL SOURCE DETAILS

Point of Contact Name:

Date:

Agency Name:

Phone:

Email:

Reason for Referral (Select Appropriate Services)

Individual Counseling Services:

- EMDR or ART
- Cognitive Processing Therapy (CPT)
- Trauma Focused CBT (TF-CBT)
- Dialectical Behavioral Therapy (DBT)
- Acceptance & Commitment Therapy (ACT)
- Cognitive Behavioral Therapy (CBT)
- Trauma-Informed Sex Therapy
- Other: *Describe in Clinical Info Section*

Family Counseling

Group Therapy

Intensive Outpatient Program

Adolescent *Adult*

Case Management

Primary Diagnosis (required) with brief description of clinically significant information pertaining to client's condition or case:

REFERRAL CLIENT DETAILS

Legal Name:

Date of Birth:

Preferred Name:

Social Security #:

Gender:

Pronouns Congruent with Gender:

Sex Assigned at Birth if Different from Gender:

CONTACT INFORMATION

Phone:

Email:

Residential Address:

If a Minor, Provide Caregiver Name:

Phone (if different):

Email (if different):

Residential Address (if different):

INSURANCE INFORMATION

Primary Insurance:

Subscriber's Name/Name on Card:

Subscriber's DOB:

Relationship to Subscriber:

Member ID:

Group ID: