



**Next Step Counseling and Education Center
Delores White, MA, LPC-S, NCC, CART, LSOTP**

Appointment Line: (361) 572-0202 - Fax: (361) 572-0300

**Victoria Office
4702 N. Laurent Suite D**

**Luling Office
1208 E. Pierce**

**Weimar Office
304 West Main St.**

Referral Form

Client's Details		Today's Date	
Client's last Name:		Client's First Name:	
Date of Birth:		Gender:	Male <input type="checkbox"/> Female <input type="checkbox"/>
Name of Parent/Guardian:		Address:	
Contact numbers:	Primary:	City/State:	Zip:
	Secondary:	Email:	
Has the parent/guardian given consent for this referral? (If Minor)		Yes <input type="checkbox"/> No <input type="checkbox"/> If no, the referral cannot be accepted	
School:		Grade:	
Insurance Provider Name:	Insured Name:	Insured Date of Birth:	Policy ID # Group #
Description of client's presenting complaint(s)/problem(s). Please provide as much information as possible (e.g. psychological/emotional/behavioral/physical/social problems, learning difficulties, developmental issues, play or peer issues, family difficulties, parenting/attachment issues and/or other). <i>Please attach additional information or copies of assessments if available.</i>			
Suicidal risk	Yes <input type="checkbox"/> No <input type="checkbox"/>	Risk of harm from others	Yes <input type="checkbox"/> No <input type="checkbox"/>
Risk of non-suicidal self-harm	Yes <input type="checkbox"/> No <input type="checkbox"/>	Other safety concerns	Yes <input type="checkbox"/> No <input type="checkbox"/>
Referrer's Details (please add email address)			
Name:		Position:	
Organization name:			
Address:		Postcode:	
Contact details:	Office:	Fax:	
	Email:		

Please attach a copy of the Insured's Insurance Card