



**Client Referral Form**  
 Barrón Morse Counseling, PLLC  
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**Client Full Name:** \_\_\_\_\_

**Date of Birth:** \_\_\_\_\_

**Gender:** \_\_\_\_\_

**Address:** \_\_\_\_\_

**Client Country of Origin:** \_\_\_\_\_

**Language spoken:** \_\_\_\_\_

**Current ability to speak English?**

**Fluent**

**Good**

**Poor**

**None**

**Parent/Guardian Name:** \_\_\_\_\_

**Language spoken:** \_\_\_\_\_

**Is an interpreter needed?**  Yes

**No**

**Home Phone Number:** \_\_\_\_\_

**Cell Phone Number:** \_\_\_\_\_

**Permission to Leave A Message?**  Yes

**No**

**Okay to Send Text Message?**  Yes

**No**

**Referral Source Name/Organization:** \_\_\_\_\_

**Referral Source Contact Information:** \_\_\_\_\_

**Client's Reason for Seeking Therapy:** \_\_\_\_\_

**Counseling Preferences (Times/Days/Types of Therapy/Gender of Therapist)**

Monday	Tuesday	Wednesday	Thursday	Friday	Saturday

**Type of Therapy:** \_\_\_\_\_

**Preferred Gender of Therapist:** \_\_\_\_\_

**Is the client in crisis?** \_\_\_\_\_

**Was crisis information given?** \_\_\_\_\_

**Is outpatient therapy appropriate for the client?** \_\_\_\_\_

**Insurance Provider:** \_\_\_\_\_

**Insurance Identification Number:** \_\_\_\_\_

**Other Insurance Information:** \_\_\_\_\_

*OFFICE USE ONLY*

*Date Referral Received:* \_\_\_\_\_

*Time Received:* \_\_\_\_\_

*Insurance Verification Information:* \_\_\_\_\_

*Date Insurance Verified:* \_\_\_\_\_

*Signature of Clinician:* \_\_\_\_\_