FCS RIVERTON
1110 Major Ave
FAX TO: 856-2668

FCS LANDER
748 Main St
FAX TO: 332-9338

REFERRAL TO FREMONT COUNSELING SERVICE

Referring Healthcare Provider / Office: _____

Referral Being Made by: _____ Date: _____

_____
ADDRESS: Street City, State ZIP

_____ _____
PHONE NUMBER FAX NUMBER

Referral's Name: _____ DOB: _____

Parent/Guardian Name(s): _____

_____
ADDRESS: Street City, State ZIP

Phone Number(s): _____
This is the number we will call to schedule an appointment.

Urgency
- ☐ Routine
- ☐ Crisis

Priority Population:
- ☐ Pregnant, intravenous drug user
- ☐ Pregnant
- ☐ Intravenous drug user
- ☐ Woman with dependent children
- ☐ Veteran
- ☐ Probation / Parole

Reason for Referral:
- ☐ MH Assessment
- ☐ SA Assessment
- ☐ Psychological Assessment
- ☐ Psychiatric Assessment
- ☐ Establish ongoing therapy
- ☐ Please call to discuss.

Current MH/SA medications (or attach MAR):

_____

Current MH/SA concerns and/or diagnosis(es):

_____

RELEASE OF INFORMATION

I / We hereby authorize Fremont Counseling Service to receive and/or release information from the Referring Healthcare Provider (above) concerning the Referral (above), as indicated below.

- ☐ Confirmation that referral entered treatment, date, name of Primary Clinician
- ☐ Diagnostic information, treatment plans, periodic progress reports

Purpose of Request: Coordination of/and collaboration during treatment.

This authorization is valid for one year from the date of signature OR until the date below, whichever comes first.

EXPIRATION DATE: _____

-- I / We understand that this release may be revoked, in writing, at any time. The revocation of release will be effective the date Fremont Counseling Service receives the written notice.

-- I / We understand that information may be shared from treatment that is pertinent to treatment outcomes with parent(s)/guardian(s) if the person receiving services is a minor.

For individuals receiving substance abuse services both the minor client AND the parent/guardian must sign this form.

_____
Referral and/or Parent/Guardian Signature Date

_____
Referring Healthcare Provider Signature Date