Intercultural Counseling Connection
Therapy Referral Request Form

Date form completed:
Completed by:

(For Connection use only):
CLIENT VL NUMBER: **Date submitted to Connection:**

Client's Name:		**Client's Phone Number/ Email:**
Client's Country of Origin:		**Client's primary language(s):**
Client age:	**Client gender:**	**Preferred language of counseling sessions (for securing an interpreter):**
Client status: ☐ Refugee ☐ Immigrant ☐ Trafficking survivor ☐ Asylee ☐ Asylum seeker ☐ SIV ☐ Other: **Survivor of torture:** ☐ Yes ☐ No ☐ Unknown		**Is client enrolled in Medicaid?** ☐ Yes ☐ No ☐ Unknown **Other insurance?**
If an asylum seeker, does client have an attorney? ☐ Yes ☐ No		**Client address (Street, city, zip code):**
Primary Contact/Individual making referral*		**Primary Contact's phone number/email:**

Please indicate what type of therapeutic support is requested:

☐ **Individual** ☐ **Women's Group** ☐ **Mother & Baby Group**

Has a release of information/permission to share pertinent details with the Connection been provided by client?

☐ **Yes** ***(if "Yes," please attach)*** ☐ **No/still to be obtained** ***(referral will be processed once ROI is provided)***

In brief, what are the main issues or symptoms client is experiencing? (i.e., chief reasons for seeking counseling)

Will a psychological evaluation or other documentation for legal proceedings be needed for this client?

☐ **Yes** ☐ **No** ☐ **Unknown**

Is the client experiencing any pressing or chronic health issues? If so, are they seeing a medical provider?

☐ **Yes** ***(if "Yes," please provide details below)*** ☐ **No** ☐ **Unknown**

What other services are currently being provided to this client /to what other programs have they been referred? ***(e.g., case management, legal aid, medical referral /HCFH or other)***

Does the client have any special needs considerations or appointment scheduling restrictions?

Does the client currently have the capacity to engage in virtual/remote counseling sessions?

☐ **Yes** ☐ **No** ☐ **Unknown**

Please add any additional relevant information about client situation, needs, or presentation:

* ***The primary contact is the individual making this referral, and/or who may assist with appointment scheduling and follow-up with the assigned Connection counselor.***

Once completed, please submit this form to the Intercultural Counseling Connection via secure email to arackowski.connection@gmail.com or via fax at (443) 835-3714.