



Cascade Counseling &
Consulting, PLLC

Referral for Outpatient Therapy

Referral Source / Phone # _____ Referring: Child Adult

Child :

Name: _____
Last First Middle

Address: _____
Street City/State/Zip County

Telephone _____ Male/Female Ethnicity _____ DOB _____
School _____ Grade level _____ Special Program _____
Medicaid #: _____ Medical Record #: _____
Social Security Number #: _____

- > Parent/Guardian Name(s): _____
- > Address: _____
- > Telephone: Home # _____ Work/Cell # _____ Best Time To Call _____

Adult :

Name: _____
Last First Middle

Address: _____
Street City/State/Zip County

DOB _____ Male/Female Ethnicity _____ Occupation _____
Telephone: Home # _____ Work/Cell # _____ Best Time To Call _____
Medicaid #: _____ Medical Record #: _____
Social Security Number #: _____

Reason for Referral:

