INNOVATIVE COMMUNITY UPLIFTING
Counseling & Mental Health Support Services, LLC

REFERRAL FOR SERVICES

(TO BE COMPLETED BY PERSON MAKING REFERRAL)

Person Referring & Agency: ______________________ **Date:** ______________

Client Name: ______________________ **DOB:** ______________

Guardian(s): ______________________ **Phone:** ______________

Address: ______________________ **Zip:** ______________

School: ______________________ **Grade:** ______________

Has the parent been notified of referral? YES NO

Type of Services Needed (circle): Family Individual Group

Brief description of current concern(s): ______________________

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Previous intervention(s) used: ______________________

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TO BE COMPLETED BY GUARDIAN

Guardian(s) Signature: ______________________ **Date:** ______________

Primary Care Physician? ______________________ **Primary Care Physician #:** ______________

Name Office

Any previous counseling sessions? YES NO

Child insured through Medicaid? YES NO

Forms can be scanned or captured by phone and emailed to info@icumentalhealth.com
Contact us at (251) 545-9659 for questions or concerns.