Access to Counseling – Referral for Services

5600 N May Ave, Suite 120, Oklahoma City, OK 73112
Phone (405) 242-2242, Fax (888) 688-7013,
www.access2counseling.com

Date of Referral: _____

Person Referred's Identifying Information			
Client's Name	**Birthdate**	**Age**	**Gender**
Client's Address	**SoonerCare ID Number**		**Ethnicity**
Apartment Number (if applicable)			
City/State/Zip	**Parent/Guardian Name (under 18)**		
Contact Phone Number	**Alternate Phone Number**		
E-Mail Address (if applicable) ☐ **DocuSign sent**			

Presenting Problems/Needs	
Summary of person referred's needs:	
☐ **Individual Therapy** ☐ **Family Therapy** ☐ **CM** ☐**BH Rehab**	☐ **Home-Based** ☐**Office-Based** ☐ **Telehealth**
Substance abuse or other addiction?	☐ **No** ☐**Yes, please describe** ☐ **Current** ☐**Past**
Suicidal/homicidal ideations, or unaddressed physical health needs?	☐ **No** ☐**Yes, please describe** ☐**Current** ☐ **Past**
Are any referrals needed for?	☐**N/A** ☐ **Testing** ☐ **Medications** ☐**Other**
History of trauma?	☐ **No** ☐**Yes**
Scheduling, counselor, etc. preferences?	

Person Making Referral	
Name	**Phone Number**
Agency or Organization (if applicable)	**E-Mail Address (if applicable)**

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Eligibility verified for: _____(month) _____(year) _____(A) _____(H)_____(OC) by _____(initials)
☐ Printout Attached Intake Clinician: _____, Urgent Needs Addressed (if any):_____
Approved by: _____Virginia Starr, MA, LPC_____
Screening: 1._____ 2._____ 3._____ 4._____ 5._____6._____ 7._____ 8._____ 9._____ = _____
10. Not Difficult Somewhat Difficult Very Difficult Extremely Difficult