# REFERRAL FORM

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Phone: 606-387-0567 Fax: 606-387-8783

CBIReferrals@cbiky.org

**Please fill out this form and either bring, e-mail, or fax to our office.**

## Client Information

Client's Name: ______________________________ Client's DOB: __________ Clients SS#: ______________________

Parent (Guardian) Name (if minor): ________________________________________ Phone: ______________________

Insurance: Yes / No Name of Insurance Carrier (if known) ________________________________________________

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## Referral Source Information

Referred by: __________________________________________________ Date: ______________________

Title/Agency: _______________________ Phone: ________________ Email: ______________________

## Reason(s) for Referral (check all that apply)

- □ Substance Abuse
- □ Mental Health
- □ Parenting Classes
- □ Anger Management Classes
- □ DUI Classes
- □ Behavior Issues
- □ Other: ____________________________

□ **CAPS Program (Collaboration and Prevention Supports)-ages 10-17**
Please check all services requested:

- □ Individual Therapy
- □ Family Therapy
- □ Substance Abuse Group
- □ Anger Management Group
- □ Drug Screening
- □ Case Management (includes pro-social activities-bowling, movies, etc.)
- □ Parenting Class for Parent/Guardian (10 sessions)

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## Brief Description of Problem:

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**To Be Completed by CBI Employee**

Staff receiving referral: ______________________________________ Date staff responded to referral: ______________________________

Comments/Action Taken:______________________________________________________________________________________________

____________________________________________________________________________________________________

Date Intake Scheduled: _______________________ Therapist: __________________________________________

DOB:__________________ SS:____________________________ Address:__________________________________________________

Insurance:__________________________________________________________________________________________