

**Group Therapy Referral Form**

**Client Information**

|  |  |  |
| --- | --- | --- |
| **Client Name:** | **DOB:** | **Age:** |
| **Address:** | **City:** | **Zip:** |
| **Contact number:** | **Email:** |  |

**Referral Source:**

|  |  |  |
| --- | --- | --- |
| **Name & Agency:** | **Contact Number:** | **Email:** |

**Reason for Referral: please include as much detail as possible including why you feel this group may be a good fit for the client.**

|  |
| --- |
|  |

**Current diagnosis (if applicable and known)**

|  |  |
| --- | --- |
| **Diagnosis code:** | **Description:** |
| **Diagnosis given by:** | **Date:** |

**Are there any safety concerns? (if yes, please provide details)** \_\_\_ yes \_\_\_ no

|  |
| --- |
|  |

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Signature Date**