Date Received by Discovery Counseling: _____

DISCOVERY COUNSELING
AND ASSESSMENT CENTER

4006 E Hwy 34, Sharpsburg, GA 30277
420 Thomaston Street, Zebulon, GA 30295
Phone: (404) 960-1282 Fax: (855) 817-2428 Email: Info@discoverycounselingllc.com
https://www.discoverycounselingllc.com/

REFERRAL FORM

Date: _____ Service Needed _____ Status: Urgent □ or Regular

REFERRAL SOURCE

First Name: _____ Last Name: _____

Phone: _____ Fax: _____

Agency: _____

Email: _____

CLIENT INFORMATION

First Name: _____ Last Name: _____

D.O.B. _____ Social Security #: _____ Male □ Female □

Insurance Name & Number: _____

Street Address: _____ Apartment/Unit #: _____

City: _____ State: _____ Zip Code: _____

Home #: _____ Cell #: _____ Work #: _____

CAREGIVER #1 INFORMATION

First Name: _____ Last Name: _____

D.O.B. _____ RelaOonship to Child: _____

Date Received by Discovery Counseling: _____

Street Address: _____ Apartment/Unit #: _____
City: _____ State: _____ Zip Code: _____

Home #: _____ Cell #: _____ Work #: _____

CAREGIVER #2 INFORMATION

First Name: _____ Last Name: _____

D.O.B. _____ Relationship to Child: _____

Street Address: _____ Apartment/Unit #: _____

City: _____ State: _____ Zip Code: _____

Home #: _____ Cell #: _____ Work #: _____

Do the caregivers have full custodial rights to make medical and educa5onal decisions for this child? ***YES*** ☐ ***NO*** ☐

Is there another parent or caregiver with joint custody we should inform about treatment? ***YES*** ☐ ***NO*** ☐

REASON FOR REFERRAL/COMMENTS:

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