Seasons Counseling Referral Form

1212 8th Street Suite #3, Baraboo, WI 53913

Office Phone: 608-448-2497

Email: referrals@seasonscounselingllc.org

Date:	Referred by:	Phone #:
Email Address of person making the referral:		

Service(s) Desired:

	Individual Psychotherapy		Recovery Education/Wellness Management
	Family Therapy/Group Therapy		Psychoeducation
	In-Home Therapy		Individual Skill Development and Enhancement
	Substance Use Counseling		Peer Support

Brief Description/Additional Information on services desired: (Example- Parent Psychoeducation Coach/Mentor, gender desired, etc.)

Name of Referred Person:	Phone:
Date of Birth:	Gender:
Address:	County:
School or Occupation:	Grade:
School Contact:	Phone:
School Contact' Email:	
County Program (CCS, MAT/MARC, CST, DCF, CLTS, ADTC):	

Availability: Monday Tuesday Wednesday Thursday Friday Saturday

Time of Day: Mornings Afternoons Evenings During School

Comments:
Reasons for Counseling / Goals:

Significant History/DSM Diagnosis:
Diagnoses:
Strengths:

Caregiver's Information

Name:	Relationship:	Phone:
Name:	Relationship:	Phone: