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**Referral Form – Del Rio, TX Office**

Date: \_\_\_\_\_ Reason for referral: \_\_\_\_\_

Referral Source and Contact #: \_\_\_\_\_

Crisis:  Yes  No (if crisis, please call) See Within:  48hrs  1 week  Next Regularly Available

Client's Name: \_\_\_\_\_ Phone: \_\_\_\_\_

If client is a minor, Parent/Guardian name: \_\_\_\_\_

DOB: \_\_\_\_\_  Male  Female  Other \_\_\_\_\_

Address: \_\_\_\_\_ City: \_\_\_\_\_

Insurance:  Yes  No Type of Insurance: \_\_\_\_\_

**Services Requested:**

- ADHD
- Anger
- Anxiety / Panic
- Behavioral Problems
- Bipolar Disorder
- Career Counseling
- Cognitive Behavioral Therapy for Insomnia
- Cognitive Behavioral Therapy for Weight loss
- Couples Counseling / Relationship Issues
- Depression
- Domestic / Family Violence
- Family Counseling
- Grief / Loss
- Health / Pain issues
- Play Therapy
- Psychosis
- PTSD / Abuse / Trauma / Rape
- Sexual Orientation / Gender Identity / Other Issues
- Substance Use Issues
- Veteran / Family Program (anyone who has ever been in the military or their family is eligible)
- Other: \_\_\_\_\_

**Specific Therapist Request:**  No preference  Spanish Speaking  Other \_\_\_\_\_

- Stephanie Blancarte, LCSW
- Alejandra Garcia, LPC,  
(bilingual)
- Marysol Musquiz, LCSW  
(bilingual)
- Daniel Perez, LPC (bilingual)
- Sandra Seca, LPC (bilingual)

Date Received: \_\_\_\_\_ Date Called: \_\_\_\_\_ Who Made Contact: \_\_\_\_\_

Appointment Made:  Y  N If No, Reason: \_\_\_\_\_