

Cornerstone Counseling Service, LLC

www.cornerstonecounselingservice.com

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 580-286-2002 (fax) 580-286-2000 (ofc)
 580-371-0434 (fax) 580-371-0433 (ofc)
 903-401-5312 (fax) 903-401-5311 (ofc)

REFERRAL FORM

Date of Referral: _____ Location: Hugo Idabel McAlester
 Tishomingo Paris

Name of Person/Client referred: _____ DOB: _____

SSN: _____ Insurance Name: _____ ID #: _____

Pay Medicaid Medicare Private Insurance Private
 Other

Address: _____ City: _____ State: _____
 Zip: _____

E-mail: _____

Phone #: _____ Parents/Guardian Name: (if applicable): _____

Has Parent/Guardian been notified of this referral? Yes

No N/A

Reason(s) for Referral:

<input type="checkbox"/>	Abuse (physical/emotional/sexual)	<input type="checkbox"/>	Depression and/or grief	<input type="checkbox"/>	Relationship problems
<input type="checkbox"/>	Academic difficulties	<input type="checkbox"/>	Difficulty communicating	<input type="checkbox"/>	Sexually acting out
<input type="checkbox"/>	Anger	<input type="checkbox"/>	Difficulty coping	<input type="checkbox"/>	Social problems/withdrawal
<input type="checkbox"/>	Anxiety	<input type="checkbox"/>	Disruptive behavior	<input type="checkbox"/>	Soiling their clothes
<input type="checkbox"/>	Autism/Asperger's	<input type="checkbox"/>	Domestic violence	<input type="checkbox"/>	Suicidal ideation/attempt
<input type="checkbox"/>	Couple's Counseling	<input type="checkbox"/>	Grief	<input type="checkbox"/>	Traumatic event

	Criminal activity		Group Therapy: _____		Trouble concentrating
	Death of family member		Mood/personality		Drug/Alcohol Test
	Death of friend		Possible drug/alcohol use		Other:
	Decline in health		Rebellious and/or verbal outbursts		Other:

Other Information:

Person/Organization referred by: _____

Phone # of referring Organization: _____

We accept most Private Insurance, Medicaid (TX & OK), Medicare (TX), & Private Pay.

(For office use only) Appointment scheduled with _____ for:
Date: _____ Time: _____