The Healthy Foundations Center

Counseling, Substance Abuse,

Life-coaching and Online Healing

Date Received:

Has the patient consented to this referral? **Yes / No**

Referral Source
G/P ☐ Self ☐
Other (please specify) ☐

Previous diagnosis and contact with mental health if known:

Patient Details			
Name			
Address			
Date of Birth		Gender	
SS#/Insurance ID#		Ethnicity	

Usually initial contact will be made by telephone: Please indicate whether a messag can be left on this number

Preferred contact number		Message Y ☐ N ☐
Alternative contact number		Message Y ☐ N ☐
Additional contact information?		
An Intake Specialst will contact the patient to discuss their needs		

Current medication:				**Other issues** (Please check all that apply)	
				Social isolation	☐
				Debt	☐
				Employment	☐
				Relationship	☐
Presenting Problem:				Housing	☐
				Other (please specify)	

Additional information
Any other info. (E.g. Referring to presenting problem, or interpreter required, special needs etc.)