Family Support and Counseling Services

Mental Health Referral

☐ Counseling ☐ Medication evaluation

Client name First: Middle: Last:	
DOB (mm/dd/yyyy): *(if available)*	**SSN:** *(if available)*
Address Street/Apt:	
City: State: Zip: County:	
Telephone:	**Health Insurance:**
Language(s) spoken:	Need Interpreter?
Referred by Name:	Position:
Agency:	Telephone:
Reason for Referral:	

Assigned To:	**Date of Referral:**

Obtained verbal consent for referral

Email referral form to counseling@ccoregon.org OR Fax to (503)688-2617