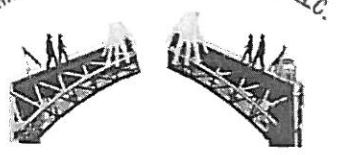
Embridge Counseling Services, LLC.



Strengthening and Empowering Individuals & Families

Referral Form

Client:		**DOB:**		**Race:**	
SS#:		**Medicaid #:**		**Gender**	
Address:					
Guardian:				**Phone#:**	
Primary Language:		**Referral Source:**			
Phone #:		**Email:**			

Last Name	First Name	DOB	SS#	Race	Gender	MH History

Reason for referral:
Any risk factors the clinician should be aware of?

Signature _____

Date _____