■ Fax: 606-806-6018

Southern Kentucky Therapeutic Interventions & Behavioral Health Services, LLC

Mental Health Referral Form

116 N. Main Street, Suite D, Somerset, KY 42501
📞 *606-392-3958* ✉️ *southernkytherapy@gmail.com*
🌐 *www.southernkytherapy.org*

Client Information

- Full Name: _____
- Date of Birth: _____ Age: _____ Gender: _____
- Address: _____
- City/State/Zip: _____
- Phone Number: _____
- Email: _____
- Preferred Contact Method: ☐ Phone ☐ Email ☐ Text

Referral Source

- Name of Referring Provider/Agency: _____
- Phone Number: _____ Fax (if applicable): _____
- Email: _____
- Relationship to Client: ☐ PCP ☐ School ☐ Court ☐ Family ☐ Self ☐ Other: _____

Reason for Referral

☐ Individual Therapy ☐ Family Therapy ☐ Couples Counseling ☐ Child/Adolescent Therapy
☐ Psychiatric Evaluation ☐ Substance Use Counseling ☐ Other: _____

Brief Description of Presenting Concerns:

Duration of Concerns: ☐ <1 month ☐ 1–6 months ☐ 6–12 months ☐ 1+ year

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Client Risk and Safety

Does the client currently have thoughts of self-harm or suicide? ☐ Yes ☐ No

If yes, please describe and indicate level of urgency:

History of psychiatric hospitalization or crisis care? ☐ Yes ☐ No

If yes, please specify:

_____

Insurance Information (if applicable)

- Insurance Provider: _____
- Policy Number: _____
- Subscriber Name: _____

Additional Notes or Requests

Referring Provider Signature: _____ Date: _____

Client/Guardian Signature (if applicable): _____ Date: _____