***FOCIS COUNSELING SERVICES, INC.***

***3000 United Founders Blvd. SUITE 103***

***OKLAHOMA CITY, OK 73112***

NEW CLIENT REFERRAL FORM

Phone: (405) 810-5032 Fax: (405) 810-5076

**Please complete all fields or mark N/A if in a field that is not applicable**

Referral Date: Referred by:

First Name: MI: Last name:

Home address:

City: ST: Zip:

Phone number: SSN: DOB:

Age: Race: Gender: Marital Status:

Type of Insurance: Insurance #:

Legal Guardian/Parent: Relationship:

Case Worker: Phone: Fax:

Court Date (if DHS): Judge: JD/JF#: Time:

Please give a brief description of the reason (s) for referral (behaviors & diagnosis-if known):

Services needed for client:

Individual Therapy Family Therapy Case Management Parenting

ADSAC 10 & 24 hour classes Anger Mgmt. Couples Therapy

ADSAC Assessments PCIT (Parent-Child Interaction Therapy)

BIP (Batterers Intervention Program) Trauma Focused Cognitive Behavioral Therapy

Bio.Mom’s name: Phone:

Address: City/ST/Zip:

Bio.Dad’s name: Phone:

Address: City/ST/Zip: