BRAVE SPACES
Counseling & Wellness

Referral for Therapy or Wellness Services

Type of service requested:

Psychotherapy Family Counseling Trauma Informed Yoga Brave Hearts Group K9-ISD

Referring person name and phone:	**Date of referral:**	**Referring agency:**
Client Name:	**Male Female** **Self Identify**	**Child Adult** **Date of Birth:**
Home Address:	**City, State, Zip:**	**Home phone:** **Cell phone:** **Email:**
Services will be funded by: CCS CPS JJ Other	**Client's Insurance company and ID#:** **Include photo of the front and back of card.** **If Badgercare *HMO*, is it through** Quartz BCBS Other	**If a child, name & phone of parent/guardian:**
Best day or time of day for appointments: (Brave Spaces Counseling cannot guarantee these times but will accommodate if possible).	**Requested location: check all that apply** In Office In School (Name of School) In Home or Community Tele-health	**Physician and medical center** **K9 (complete for services only)** Client have own dog Yes No Rabies vaccine date (must be current)

List others living in the household:

Name:	Age:	Relationship to client:
1.		
2.		
3.		
4.		

Reason for Referral: (Include history, presenting concerns, diagnoses, pertinent info.) Use back side or another sheet if necessary

What are your primary goals for our work with this client and/or family?

Missing information will delay services. ***Send completed form to: Kim Fredricksen Attn: Referrals***

At: ***605 4th St. South, La Crosse, WI. 54601, kim@brave-spaces.org***

After referrals are received intake paperwork will be sent if we are able to add this client/family. We will confirm the receipt of your referral and update you on availability to open this client/family within 2 business days.