guardianhouse
a safe space

Client Referral Form

Please return this form via email to: intakes@guardianhouse.org
Or fax form to: 210-733-7755
For questions, please contact our Intakes Department
Email: intakes@guardianhouse.org Ph: 210-733-3349

Date of Referral:_____

Referring Agency

Agency/Org: _____ Contact Name: _____

Phone: _____ E-mail: _____

Address: _____

Client Information

Name: _____ DOB: _____ Gender: ☐ Male ☐ Female

Phone: _____ Email: _____ ☐ Other: _____

Is the client a minor (under 18 years) and/or have a legal guardian? ☐ Yes ☐ No

If Yes, Name of Parent/Legal Guardian:_____ Phone:_____

Preferred method of contact: ☐Phone ☐ Email Ok to leave voicemail? ☐ Yes ☐ No

Party responsible for payment:

☐ Client ☐Parent/ Legal Guardian ☐Referring Agency ☐Other: **Type**

of Services Requesting:

☐ Individual Counseling ☐ Couples Counseling ☐ Family Counseling ☐ Reunification Counseling ☐ Parenting Education Classes

Reason for Referral:

_____

_____

Are the requested services mandated by a court, your agency or any other entity? ⬜ Yes ⬜No

If Yes, Name of party mandating services:

_____ Required Number of Session and/or desired outcome: _____

*****The following question is optional but helps us determine eligibility for specific programs and funding assistance. Please answer to the best of your knowledge*****

Is client a victim/survivor of domestic violence, sexual assault, stalking or any other form of abuse? ⬜ Yes ⬜ No ⬜ Unknown

Other comments:

Authorization to Disclose Information for Referral to Guardian House

I authorize (referring agency) _____ to disclose information about me to Guardian House for the purpose of expediting my referral and coordinating services. By signing below, I authorize the exchange of information around the status of beginning services.

Check one of the following:

⬜ You may disclose all the information you have about me.
⬜ You may disclose only the following information: _____

I ⬜do ⬜do not authorize the disclosure of my health information regarding:

⬜ HIV/AIDS
⬜ Alcohol and drug abuse treatment

Unless this authorization is revoked earlier, it expires:
(list the date, event or condition)

_____

please note, unless otherwise stated above, this authorization will expire after 1 year from date signed

_____ _____
Signature of Individual or Parent/Legal Guardian **Date (DD/MM/YY)**

_____ _____
Printed Name **Relationship to Client**