



Referral Form

Horse Sense of the Carolinas, Inc.

Client Name _____ Age: _____ D.O.B: _____ SS# _____ M / F

Address: _____ City & State: _____ Zip Code: _____

Home Phone: _____ Work Phone: _____ Cell Phone: _____ Message OK? Y / N

Caller Name: _____ Phone# _____ Relationship to Client: _____

Legal Guardian: (must sign all paperwork)

Legal Guardian phone numbers: H _____ W _____ C _____

Reasons seeking therapy: _____

Previous Treatment? _____ Provider: _____

Existing Diagnoses? _____

Psychiatric Hospitalization in past year? _____

Legal Involvement: _____ On probation? Y / N

Medications: _____

Prescribed by: _____ Current Therapist: _____

Medical Issues we should know about: _____

Referring Organization/Contact Person: _____

Who will provide transportation? _____

Please Mark Funding: Self-Pay/Private Ins. (payment due at session) Medicaid Grant Scholarship Fund (waiting list)

For Office Use Only

If Phone Screening: Answered by: _____ Date: _____

Client Contacted for Intake by: _____ Date: _____

Intake Made for this date and time: _____ with this therapist: _____

If Outside Referral: Fax Received by: _____ Date: _____

Client Contacted for Intake by: _____ Date: _____

Intake Made for this date and time: _____ with this therapist: _____

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