Health. Justice. Hope.

Adult Counseling Referral Form

Please fax form to: Intake & Referral @ (503) 352-1088

- Date of Referral: ________________________________
- Name: ____
- Phone #:_____________________________Is Voice Mail OK: ___
- D.O.B.: ____________________________ Gender: ____________
- Email: __________________________________
- Address: ____

  ____
- Language(s) spoken: _____________________Country of Origin: __________
- Referent name and role: ______________________________________
- Referent Tel #: _________________ Email: ____________________
- Does client know about the referral? ___________
- OHP #: _______________________________________
- Is client ready to be on a waitlist for 2-4 weeks? _______
- Availability for sessions:_________________________________
- Nature of Referral: Routine or Urgent
- Risk of harm to self or others? Yes ☐ No ☐

  Please explain: ____
- Reason for referral:

  ____

  ____

3800 SW Cedar Hills Blvd.Suite 288 Beaverton, OR 97005 Phone: (503) 924-2448 Fax: (503) 352-1088

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