R.E.A.C.H. For Tomorrow Inc
Business Phone I 1-877-99REACH I Fax I 937-288-8040
Office and Mailing Address: 910 South Street, Greenfield, OH 45123

R.E.A.C.H. New Client Referral Form

* INDICATES REQUIRED FIELD

*Name (first, last) *Date of Birth (mm/dd/yyyy)

*Address

*City, State Zip Code Residing County

*Email *Contact Number

*Which county and/or school are you requesting services for?

Clients Age
- ☐ Younger than 13
- ☐ 13-18
- ☐ 19-25

*Are you interested in Equine (Horse) Therapy? (Located in Washington CH area)
- ☐ Yes
- ☐ No
- ☐ Would like more information

Were you referred to R.E.A.C.H?
- ☐ No
- ☐ Yes, who _____

Are you requesting a specific counselor?
- ☐ No
- ☐ Yes, who _____

*Brief Summary of Presenting Issue(s) (Please include current diagnosis' and medication if known) :

*IMPORTANT INFORMATION PLEASE REVIEW FOR YOUR BENEFIT

This form can be returned via email to both kristaj.reach4t@gmail.com and ronda.reach4t@gmail.com (prefered) or returned to the R.E.A.C.H. contractor that you received it from.

If you are a school official referring a student for counseling services, please have the student and caregiver/guardian complete the attached *Release of Information* noted on the following page.

Please note that once you submit/return your completed *Referral Form,* you will then be sent a link via email and/or phone to complete our online *Intake Form.* These forms are prudent to get the requested individual into counseling services, so please be sure to complete all required forms, especially the requested insurance information as this often can cause a delay in the registration process.

Once all *Intake Forms* are complete, our Operations Manager will then assign the requested client/individual with one of our assessors who will be in contact with the client's caregiver/guardian to schedule an *Diagnostic Assessment*. Once the client's *Diagnostic Assessment* is complete, the requested and/or assigned clinician will be in contact to schedule and begin providing *counseling services* to the specified client.

If you have any questions or concerns regarding your referral or the referral process, please do not hesitate to reach out.

Sincerely,

Krista Jones, MSW, LISW
Independent Contracting Therapist
Clinical Manager
Trauma Specialist
kristaj.reach4t@gmail.com
c: (740) 656-3386

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R.E.A.C.H. Release of Information

AUTHORIZATION TO DISCLOSE CLIENT INFORMATION

*Client Name (first, last) *Date of Birth

*Program/Individual Authorized To Make Disclosure (e.g. School, Probation, etc.)

*Program/Individual Authorized To Receive Information (e.g. Reach for Tomorrow)

(can check multiple boxes)

*The following programs are authorized to:
- ☐ Disclose
- ☐ Receive
- ☐ Exchange

*Purpose of Disclosure:
- ☐ To coordinate treatment
- ☐ To gather assessment information for treatment planning
- ☐ To gather information for ongoing treatment
- ☐ Other purposes

*Amount of Information to be Disclosed:
- ☐ Information covering the previous three months
- ☐ Information covering the most recent admission
- ☐ Other amounts of information

Authorization to disclose expires 1 year after completion unless otherwise noted: _____

☐ **I hereby consent and authorize to the listed disclosure**

***Signature of Client or Other Person Authorized to Permit Disclosure** **Date**

***Signature of Staff or Witness** **Date**

This authorization is subject to written revocation at any time except to the extent the program or person who is authorized to make the disclosure has already acted in reliance on it.
If you chose to revoke this consent at anytime in the future you will be asked to sign the following revoke consent:

Client Signature **Date**

Staff/Witness Signature **Date**