



Outpatient Referral Form

Referral Source Information:

Person Making Referral: _____ Date: _____

Referral Organization: _____ Phone #: _____

Case Manager- Contact Person: _____

Case Manager – Contact Person Email: _____ Phone Number: _____

NOTE: AGUAS Staff will send an email informing the Case Manager – Contact Person when the referred individual schedules the initial evaluation appointment; recommendation (service plan) from the assessment; and if services are accepted by referred individual – AGUAS will send a monthly report until completion. If there are any non-compliance issues – AGUAS will send that report in addition to the monthly reports.

Client Information:

Client Name: _____ Date of Birth: _____

Client address: _____

Email: _____ Phone #: () _____ - _____

Reason for Referral Additional info: : _____

Parent/Guardian Name: (if applicable): _____ Phone: () _____ - _____

Language Requested: ___ Spanish or ___ English

Client’s Release of Information: I authorize this referral source to the information on this form with AGUAS-Latino Counseling Services, LLC for the purpose of discussing and scheduling my appointment. An additional release of information will be required at appointment with AGUAS.

Divulgación de información del cliente: Autorizo a esta fuente de referencia a compartir la información en este formulario con AGUAS-Servicios de Consejería Latino, LLC con el fin de conversar y programar mi cita. Se requerirá una divulgación adicional de en la cita con AGUAS.

Client signature- Firma: _____ Date/Fecha: _____

please attach incident/police reports

Please advise referred Client to contact AGUAS staff within two (02) business days (540) 372-7211

Client Referred for: (check one or more boxes below)

- Anger Management program** – learn about anger, effective way to manage/express anger; learn effective ways of communicating emotions
- Domestic Violence program** – address, identify behaviors to stop aggression and abuse
- Psychotherapy/Counseling** – Depression, Anxiety, Substance use, Behavior change (smoking cessation, healthy eating, etc.), Personality disorder, Relationship issues, Stress management, etc.
- Substance Abuse Evaluation**– Assessment to determine level of care needed (Outpatient, IOP, Sub-Acute Detox)
- Other:** _____

Please explain: _____

please attach incident/police reports PHQ-9 Score (If available): _____

Email this form to: aguasconsejeriatino@gmail.com