KINDER
KONSULTING

& Parents Too

Fax Referral To: 407-894-6010

DEMOGRAPHIC INFORMATION

Name: _____ **Social Security #:**_____

Parent/Legal Guardian:_____ ***Relationship to Client:** _____

Address: _____ **County:**_____

City/State: _____ **Zip:**_____

Phone:_____ **Phone #2:**_____ ***Email (Required)**_____

Sex: ☐**M** ☑**F** **Race:** ☐**White** ☐**Black** ☐**Hisp** ☑**Haitian** ☑**Bi-Racial** ☐ **Other** **Birth Date:**_____ **Age:** _____

Legal status: ☐**Minor in parent/guardian custody** ☑**Minor in state custody - Legal Guardian Date of birth** (Required)_____

School: _____ **Caregiver's primary language:**_____ **Bilingual needed?** ☑**yes** ☐**no**

OTHER CURRENT SERVICES

☐No current services

☐Mental Health Counseling: Name/Agency:_____ Phone:_____

☐Psychiatric/Medication: Name/Agency:_____ Phone:_____

☐Other: _____ Name/Agency:_____ Phone:_____

REFERRAL SOURCE INFORMATION

Referring Agency: _____ Person completing form: _____

Phone: _____ Fax:_____ Email:_____ Date:_____

SERVICES REQUESTED: ☐**Counseling** ☐**Behavior Therapy** ☐**Play Therapy** ☐**Psychiatry(only clients)** ☐**Psychological Testing** ☐**Applied Behavior Therapy (In office)** ☐ **Trauma** ☐**PCIT**

FUNDING INFORMATION

☐**Medicaid ID#:**_____ **Sunshine / CMS / Humana /Simply** ☐**Other** ☑**Other Insurance:**

_____ **ID #:** _____ **Group #:**_____

Insurance Phone: _____**Auth info:** _____**(copy of insurance card required)**

PROBLEM DESCRIPTION

Please circle & describe symptoms to be treated:

Physical Aggression	Failure to Thrive	Tantrums	Lying	Depressed Affect
Verbal Aggression	Property Destruction	Truancy	Victim of Abuse	Anxious Affect
Non-Compliance	Disruptive Behavior	Stealing	Self-Injury/Suicidal	Toileting Problems

Please Describe Reason for Seeking Services:

_____

_____

_____

_____

FOR OFFICE USE ONLY:
Clinician Assigned:_____ Date Assigned: _____

REFERRALS CAN BE SUBMITTED ONLINE AT https://www.kinderkonsulting.com/referralform.php *Updated 07/26*