Stone Counseling
Services, LLC.

Referral Form

Jeff Stone MSW LISW Phone: 614-407-4212 Email:jstone@stonecounselingservices.com

Client Information:

Client Name: _____

Parent/Guardian name:_____

Client Address: _____

City/State/Zip: _____

Home Phone:_____

Work Phone: _____

Date of Birth: _____

Gender: _____

Insurance Provider: _____

Insurance Member Number: _____

Referring Agency Information:

Agency Name :_____

Worker Name:_____

Address:_____

City/State/Zip:_____

Phone:_____

Email:_____

Requesting Type of Services:

☐ Individual Counseling

☐ Family Counseling

Presenting Issues (mark all that apply)

☐ Aggressive	☐ Depression	☐ Inappropriate Sexual Behavior
☐ Anger Issues	☐ Disruptive Behaviors	☐ Self Abuse or Mutilation
☐ Anxiety	☐ Emotional Outburst	☐ Sleep Problems
☐ Argumentative or Uncooperative	☐ Hallucinations	☐ Social Isolation or Withdrawal
☐ Danger to self or others	☐ Homicidal Ideation	☐ Suicidal Ideation
☐ Defiant	☐ Impulsive	☐ Other: _____

Authorization: I authorize the referring agency/worker above to refer my child for mental health services to Stone Counseling Services LLC. Also, so that they may coordinate care and treatment for my child, I give my permission for the referring agency/worker and mental health professional to communicate about the needs and course of action with respect to my child. I understand that I may reevoke this permission at any time either in person or in writing

Parent/ Guardian Signature:_____ **Date**:_____