



NEW DIRECTIONS THERAPEUTIC CENTER

11821 East Freeway • Suite 320 • Houston, TX 77029
Phone 713-804-9555 • Fax 713-804-9553 • www.new-dtc.com

Mental Health Services Referral Form

Thank you for your referral. Our agency will contact you to confirm that the referral has been received. Please discuss the nature and intent of this referral with your client. We will contact the client to schedule an appointment.

Referral Date: _____ Referral Source (Agency & Name): _____
 Referral Source Address: _____
 Referral Contact #: _____ Referral Fax #: _____

Client Name: _____ D.O.B.: _____ Gender: _____
 Ethnicity: _____ Language: _____ Interpreter: Yes No
 Address: _____
 Contact #: _____ Legal Representative: _____
 Grade: _____ School: _____ Insurance: _____
 Diagnosis: _____ Social Concerns: _____
 Services Requested: Individual Therapy Family Therapy Parenting Support Case Management
 Medication Management Psychosocial Rehabilitation
 Are there any other agencies currently involved in the client's care: No Yes, _____
 Reason for referral:

Signature of Referral Source: _____
 Printed Name of Referral Source & Title: _____
 Signature of Parent (if possible, to obtain): _____
 Printed Name of Parent: _____

Please let the family know that we will reach out to them within 48 hours of receiving the referral.

Please fax this completed form to: (713) 804-9553 or

Email this form to: info@new-dtc.com