Healing Hoofbeats, LLC

Phone: (860) 459-4115 www.healinghoofbeatsllc.com

Referral Form

Date: _____

Client Name: _____ DOB: _____ Age: _____

Gender: _____ Culture/Ethnicity: _____

Address: _____

Phone Number: _____ Can a message be left? Y N

Parent/Guardian Name (if under 18): _____

Parent/Guardian Phone Number: _____

Emergency Contact: _____ Phone: _____

Referral Source: _____ Phone: _____

Name of worker: _____ Title: _____

Phone: _____

Presenting Problem: _____
_____
_____
_____

Services Requesting: _____

Previous Mental Health Provider(s): _____

Suicidal/Homicidal/Aggressive/Risky behaviors of concern: _____
_____

Do you have insurance that you would like to use? Yes No If yes, who is your insurance carrier?
_____ Number: _____

Site Preference: Harwinton North Franklin

Please send back to Renee Bouffard, LCSW via:
Email: healinghoofbeatsllc@gmail.com
Fax: (860) 733-0323