

# NEW LIFE COUNSELING SERVICES

2737 DeHoop Ave. SW, Wyoming, MI 49509  
Phone (616) 249-1888 Fax (616) 249-1890

## REFERRAL FORM

### CLIENT INFORMATION

Client Name \_\_\_\_\_  
DOB \_\_\_\_\_  
Address \_\_\_\_\_  
City \_\_\_\_\_ Zip \_\_\_\_\_  
Phone \_\_\_\_\_  
Offense \_\_\_\_\_ BAC \_\_\_\_\_  
Probation End Date \_\_\_\_\_

### REFERRAL AGENCY INFORMATION

Referred by \_\_\_\_\_  
Court/Agency \_\_\_\_\_  
Date of Appointment \_\_\_\_\_  
Time of Appointment \_\_\_\_\_

\_\_\_\_ Client will call for an appointment by the following date \_\_\_\_\_

#### REASON FOR REFERRAL/SERVICES:

- \_\_\_\_ Substance Abuse Assessment  
Recommendation needed by: \_\_\_\_\_
- \_\_\_\_ New Beginning Group (6 Sessions)
- \_\_\_\_ Substance Abuse Awareness Program  
(SAAP-10 Sessions)
- \_\_\_\_ Relapse Prevention Group (Gender Specific)
- \_\_\_\_ Intensive Outpatient Program (IOP)
- \_\_\_\_ Individual Counseling Session
- \_\_\_\_ Alcohol Highway Safety Education  
(21 Years or Older – First Time Offenders)
- \_\_\_\_ Minors In Possession (MIP) (Ages 17 – 20)
- \_\_\_\_ Cocaine Specific Education (12 Sessions)
- \_\_\_\_ Anger Management Group (12 Sessions)
- \_\_\_\_ Marijuana Specific Group (8 Sessions)
- \_\_\_\_ To Be Determined by New Life Counseling

#### TESTING DETAILS:

Please specify frequency  
of each type of service:

- \_\_\_\_ THC \_\_\_\_ Cocaine \_\_\_\_ PBT
- \_\_\_\_ 4 Panel  
(THC, COC, mAMP, OPI)
- \_\_\_\_ Daily \_\_\_\_ Weekly
- \_\_\_\_ BiWeekly \_\_\_\_ Monthly
- \_\_\_\_ One Time Only Date \_\_\_\_\_
- \_\_\_\_ Random

#### Client History:

Prior Convictions \_\_\_\_ Yes \_\_\_\_ No  
Assault History \_\_\_\_ Yes \_\_\_\_ No  
Probation Violations  
\_\_\_\_ Yes \_\_\_\_ No

Other comments: \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

I \_\_\_\_\_ hereby authorize New Life Counseling Services, its director or designee, to release information to (person and/ or referring agency) and to receive information from \_\_\_\_\_. The extent and nature of the information will concern my attendance and progress in the program, and when necessary, offer recommendations.

The purpose of this disclosure is to assist the referring agency in reaching a satisfactory disposition of my case. This authorization will remain in effect until the purpose for which it was given no longer exists. In the case of a criminal justice referral, the authorization will expire when the program receives official written notice of my legal status.

Client \_\_\_\_\_ Date \_\_\_\_\_

Referral Agent: \_\_\_\_\_ Date \_\_\_\_\_

