Inner Reins Counseling

Phone: 772-222-7216 **Email:** innerreinscounseling@gmail.com

Date of referral: ______________________________ **Referral Source:** __________________________

Reason for Referral:

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Service(s) Requested:

o Child-Parent Psychotherapy (CPP) *parent-child therapy* (Does not have to have DCF involvement to refer)
o 8-week Circle of Security Parenting Class
o Grief, Loss, and/or Post-Abortion Counseling
o Individual therapy for parents (maternal/paternal mental health)
o Through the Eyes of the Child-6 week CoParenting Intervention
o Training/Presentation on Attachment, Maternal Mental Health, Infant Mental Health

Client's Information:

Client/Organization name: ________________________________ **Date of birth:** ____________
Address: ____
Biological parents' names: ____
Phone: ___________________________________ **Email:** _______________________________________
Caregiver/Foster parents' names: (if applicable)
____ **Phone:**_________________________________
DCM name: ________________________________ **Phone:** ____
Email: ____
Insurance carrier: __________________________________ **Member ID:** _________________________
****Please provide COPY of Insurance CARD**
If child has been sheltered, please explain the visitation schedule:
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Please be advised that the acceptance of referrals is contingent upon scheduling availability and geographical location. You will receive notification regarding the status of your referral within three days of its receipt. Thank you for your referral. It is our pleasure to collaborate with you and the family being referred.