Professional Referral Form

Please fax this form to (614) 656-1180 or email to office@icftcolumbus.com
If the person you are referring is in immediate danger, please contact 911

Name of Potential Client: ________________________________ **Date:** __________________

Date of Birth: _______________________ **Phone Number:** _______________________

Referred By - **Name:** _____________________________________

Profession: _____________________________ **Organization:** _______________________

Phone Number: _________________________

Requesting:

- ☐ **Individual Therapy**
- ☐ **Couples Therapy**
- ☐ **Family Therapy**
- ☐ **Full Written Assessment**
- ☐ **Diagnostic Second Opinion**
- ☐ **Treatment Plan Second Opinion**

Please explain your reason for referral.

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