ICFT
Individual, Couple, and Family Therapy

Professional Referral Form

Please fax this form to (614) 659-0360 or email to kristen@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.

_____

_____

_____

_____

_____

_____

_____

_____