FOR OFFICE USE ONLY:

Therapist: _____________

Intake: _______________

FOR OFFICE USE ONLY:
___/___: _____________
___/___: _____________
___/___: _____________
___/___: _____________

Date of Referral: ____________

To refer an individual for therapy at the Tree House, please complete this form and return to Molly Cupid at molly.cupid@montgomerycountymd.gov

Referral for Therapy

Agency and Department requesting mental health services:

____

Social Worker requesting mental health services:

Name:____________________________Phone:____________________Fax:______________________

Client:

Name:_____________________________DOB:_____________City:_____________________________

Brief history of concerns (example, history of child physical abuse and subsequent behavioral problems to include aggression; history of child sexual abuse and subsequent reports of suicidal ideation; etc):

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____
____

Name and phone number of legal guardian (or the person with whom we should schedule the intake):

____

Preferred language of client: _____________ Preferred language of parent: _______________

Insurance info, if any: ____

Please return this form to Molly Cupid. Suite 700; .
Email: molly.cupid@montgomerycountymd.gov ● Phone: 240-777-4699 ● FAX: 240-777-4470