CORNERSTONE
TREATMENT
CENTER

Referral & Consent

Free Mental Health Screenings | Statewide
Email Referrals To:info@ctreatmentcenter.com
Call: 573-550-3911 | Fax: 972-292-9638

CLIENT INFORMATION ☐ Child (5-12 yrs) ☐ Adolescent (13-17yrs)

Client Name: _____ Date of Birth: _____

Parent/Guardian (If Applicable): _____ Phone#: _____

Address: _____ City:_____ State: _____ Zip: _____

Insurance Provider: _____Subscribers Name: _____

Member ID / Group ID: _____

Email: _____

Recommendations for the Following Service (s) ☐ Free Mental Health Screening
☐ Initial Assessment ☐ Partial Hospitalization ☐ Intensive Outpatient Programming
Group programming includes Individual Therapy, Family Therapy, and Medication Management part of programming. ☐ Residential Treatment Center (Must be Referred by Child Protective Services)
Diagnosis/Concerns:_____

CONSENT ****** PLEASE COMPLETE THIS SECTION******

Client's Release of Information: I authorize referral source to communicate with Haven Treatment Center for the purpose of tele screening, communication, and scheduling my appointment. An authorization to release protected health information form will be required to discuss treatment. I am aware that any missed appointments scheduled will be communicated with referring physician or referral source.
Client Signature: _____ Date: _____
☐ Please check box if client provided verbal consent.

Referral Source Information ☐ ISD ☐ Court ☐ Provider ☐ Other

Person Making Referral: _____

Referral Organization: _____Phone#_____

Office Contact Person: _____ Fax# _____

Email: _____

Haven Treatment Center Area ☐1st Attempt_____ ☐ 2nd Attempt ____ ☐ 3rd Attempt____
Appointment Scheduled: Date: _____ Time: _____

Client Unable / Declined to schedule: Reason: _____

Note: _____

Haven Treatment Center team member completing this document: _____