



Contact Us:

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Address:
1210 E Park Ave
Tallahassee, FL 32301

Referral Form

*To be completed by referring provider

Client Name

Date of Birth

Parent / Guardian (If Adolescent)

Client / Guardian Phone #

Diagnosis/Concerns:

Recommendation for the Following Service(s):

Eating Disorder Services

- Eval / Program Assessment
- Outpatient Therapy
- Medical Nutrition Counseling
- IOP / PHP Programs

Other Therapy Services

- Individual Counseling
- Group Therapy / Support
- Music Therapy
- Art Therapy

Nutrition Counseling

- Diabetes Prevention
- Weight Management
- Special Dietary Needs
- Other: _____

Marriage & Family Therapy

- Premarital Counseling
- Couples Counseling
- Divorce
- Family Relationships

Maternal Mental Health

- Individual Counseling
- Group Therapy / Support
- Co-Parenting / Couples Support
- Adoption

Other:

If other, please define:

Referring Provider / Contact: _____

Phone: _____

Referring Agency / Office: _____

Phone: _____

Signature: _____

Date: _____