TRC Wellness
Integrative Health Care + Research
CLARITY | ALIGNMENT | RELATIONSHIP | EXCELLENCE

Client Referral Form

In Person ☐ Online ☐

SECTION 1: Referral Details

■ Routine ☐ Priority ☐ Urgent ☐

If this is an emergency, call 911 or dial 988.

SECTION 2: Client Information

Full Name: _____

DOB: _____

Phone: _____

Email: _____

Address: _____

Preferred Contact: ■ Phone ☐ Email ☐ Text ☐

SECTION 3: Parent/Guardian

Name: _____

Relationship: _____

Phone: _____

SECTION 4: Insurance

■ Medicaid ☐ Medicare ☐ Private ☐ Self-Pay ☐ Unknown ☐

Provider: _____

Member ID: _____

(P) 312.610.3708| (F) 773-690-6893 | (E) support@trcwellness.org
1105 w. Chicago Avenue, Suite 301, Chicago Illinois, 60642

SECTION 5: Referral Source

Organization: _____

Contact Name: _____

Phone: _____

Email: _____

Consent to contact: Yes ☐ No ☐

SECTION 6: Requested Services

■ Individual ☐ Couples/Family ☐ Child/Teen ☐ IOP ☐ Faith-Integrated ☐

■ Rapid Access ☐ Safety Planning ☐ Stabilization ☐ Care Coordination ☐

■ Case Management ☐ Resource Navigation ☐ Goal Planning ☐ Ongoing Support ☐

SECTION 7: Presenting Concerns

_____

_____

SECTION 8: Risk Screening

■ None ☐ Suicidal Thoughts ☐ Self-Harm ☐ Substance Use ☐ Psychosis ☐ Other ☐

SECTION 9: Urgency

■ Routine ☐ Soon ☐ Urgent (24–72 hrs) ☐

SECTION 10: Consent

■ Client/Guardian consent obtained

Signature: _____

Date: _____

SECTION 11: Internal Use Only

■ Referral Received

■ Insurance Verified

■ Risk Flagged

■ Assigned Clinician

■ Scheduled