The Ellis Human Development Institute
Referral Request for Evaluation and Treatment

Please note: Due to the confidential nature of this request, a release of information form must be signed by client and forwarded with this referral.

Fax form to (937) 775-4311

Date of Referral: _____

Referring Agency: _____

Referring Physician/Contact: _____ **Phone:** _____ **Fax:** _____

Client Medical Information (please print)

Client Referred: _____ **DOB:** _____
(Last, First, MI) (Phone)

Client/Guardian _____
(Name) (Phone)

❑ Client provides consent for the Ellis Institute to leave a message on the phone number above

Reason for Referral: _____

Requested Service (choose all that apply):

- ❑ Psychological Testing (including evaluation for learning disabilities and ADHD)
- ❑ Individual Counseling
- ❑ Group counseling
- ❑ Couples, relationship, and/or family counseling
- ❑ Trauma-informed services, including assessment and counseling (Center for Posttraumatic Recovery)
- ❑ Dialectical Behavioral Therapy for women (individual or group counseling)
- ❑ Affirmative Counseling for LGBTQ+ individuals
- ❑ Other _____

Client's Primary Medical Diagnosis: _____

Other Medical Diagnoses: _____

Other mental health services that the client is already receiving: _____

REFERRAL SIGNATURE _____ **DATE:** _____

Appt. Date: _____ **Time:** _____**AM/PM** **Scheduled with:** _____