All-Desert Mental Health and Wellness
73-726 Alessandro Dr., Ste. 203
Palm Desert, CA 92260
Phone (760)797-5151 Fax (760)296-1790

Referral Form
CONFIDENTIAL

Name of Client: _____ DOB: _____ Age: _____
Address: _____ City/State: _____ Zip: _____
Home Telephone: _____ Work: _____ Cell: _____

Reason for Referral:_____
_____
_____
_____

Issues of Concern:

Domestic Violence _____
Child Abuse _____ Type: _____
Aggressive/acting out behaviors _____
Parenting education _____

Drug/Alcohol Use _____
Child Neglect _____
Other mental health issues (depression, anxiety, personality disorder, etc.)
_____

History of Similar Problems: _____
_____

Medical Issues: _____
Medications: _____ _____
_____ _____

Dangerous Behaviors (danger to self, suicide attempts, danger to others, weapons in the home, dangerous home environment, etc.): _____
_____

Referring Professional/Agency: _____
Phone: _____ Contact Person: _____
Address: _____

Authorization for Release of Information (must be signed by client)

I, _____, hereby authorize _____ to exchange information with All-Desert Mental Health & Wellness (ADMHW). The information to be released is limited to my referral to ADMHW and potential treatment concerns. This authorization shall remain valid for one year or _____ (as specified by client) from the date of my signature.

Signature of Client: _____ Date: _____

PLEASE FAX FORM TO (760)296-1790 or EMAIL to codyadwc@gmail.com