Referral List Information Form
for Mental Health Professionals in Private Practice

Name:____ **Date**:______________________

Office Address (primary & secondary, if applicable):

Street:____ City:_________________ Zip:__________

Street:____ City:_________________ Zip:__________

Office Telephone(s):_______________________________ **Fax**:__________________________________

Email:_______________________________________ **Provide email to individual being referred?** ❑ Yes ❑ No

PROFESSIONAL & DEMOGRAPHIC INFORMATION

Degree:________ **Year**:________ **Granting Institution**:____

License/Registration Type & Number:____________________________ **Effective Date**:____/____/____ **State**:___

Supervisor's Name (if applicable):_____________________________ **Supervisor's Phone**: _________________

The following demographic information ***will*** *be provided to individuals if requested or relevant for making a referral.*

Age:_____ **Gender:** ❑ Female ❑ Male **Ethnicity**:____

Affectional/Sexual Orientation: ❑ Lesbian/Gay ❑ Bisexual ❑ Heterosexual

Language Fluency: ❑ English ❑ Spanish ❑ Other: ____

CLINICAL SERVICES

Services Offered

❑ Individual Therapy ❑ Couples/Marital Therapy ❑ Family Therapy ❑ Child Therapy ❑ Consultation ❑ Testing

❑ Group therapy (please describe):____

❑ Other:____

(Continued)

CLINICAL SERVICES (con't.)

Clients served: ❑ Children ages ____ to ____ ❑ Adolescents ages ____ to ____ ❑ Adults ages ____ to ____

Specialty Areas

❑ ADD/ADHD
❑ Anxiety disorders
❑ Assertiveness training
❑ Bipolar Disorder
❑ Chronic illness/medical conditions
❑ Conflict resolution
❑ Crisis intervention
❑ Depression
❑ Dissociative disorders
❑ Eating disorders
❑ Grief/bereavement
❑ HIV/AIDS
❑ Learning disabilities
❑ Lesbian/gay/bisexual issues
❑ Men's issues
❑ Military/veterans' issues
❑ Multicultural issues
❑ Pain management
❑ Personality disorders
❑ Psychopharmacology/medication management
❑ Physical abuse
❑ Physical health/wellness
❑ Psychological testing
❑ Psychotic disorders
❑ Rape/sexual abuse
❑ Relationship issues
❑ Relationship violence
❑ Sleep disorders
❑ Stress management
❑ Substance abuse
❑ Transgender issues
❑ Trauma/PTSD
❑ Women's issues
❑ Other:______________________
____

Please describe LGBTQ-related professional experience: ____

____

____

Office Hours (days & times):____

Standard Fees: $ _____________________ **Sliding scale?** ❑ No ❑ Yes, $ _____ to $ _____

Insurance accepted: ____

____

Any exclusions about your practice that we should know about when referring clients to you?

____

Any other information about your practice that you would like us to have? _________________________________

____

Please feel free to attach a vita, brochures, or any other materials you would like us to have.

Your signature below acknowledges that you understand that clients may be provided with the information provided on this form and that you have the professional training and experience to provide services to lesbian, gay, bisexual, and transgender individuals.

SIGNATURE:______________________________ **DATE:**____/____/____

Please mail completed form to the North County LGBTQ Resource Center at the address below.

▼ 510 North Coast Highway, Suite C, Oceanside, CA 92054 ▼ www.ncresourcecenter.org ▼ (760) 672-1848
▼ A 501(c)3 Non Profit Organization ▼ Tax ID 39-2069596