Family Service of Roanoke Valley
Strengthen Families. Heal Trauma. Restore Hope.

10/22/2018

Referral for Services

Received: _____

PLEASE ENSURE THE BELOW INFORMATION IS CORRECT AND COMPLETE.

Client Information

Client Name: _____

Guardian Name: _____
(If applicable)

Sex: ☐ Male ☐ Female

Date of Birth: _____ **Age:** _____

Address: _____

_____

County / Locality:
☐ Bedford County ☐ Botetourt County ☐ Craig County
☐ Franklin County ☐ Roanoke City ☐ Roanoke County
☐ Salem ☐ Vinton ☐ Other: _____

Phones: ○ **Cell:** _____ ○ **Home:** _____ ○ **Work:** _____
(Mark preferred)

Email: _____ ☐ Family Service may contact me via email if necessary.

Primary Language: English Spanish Other: _____

Do you have insurance? ☐ Yes ☐ No **If so, please list the insurance information below.**

Primary Insurance company name: _____

Member ID: _____

Secondary Insurance company name: _____

Member ID: _____

Best day of the week for appointments. Circle all that apply:

Monday Tuesday Wednesday Thursday Friday Any

Best time for appointments. Circle all that apply:

Mornings Afternoons Evenings Any

Hours of Operation

Monday-Wednesday: 8:30am - 8:00pm
Thursday: 8:30am - 6:00pm
Friday: 8:30am - 5:00pm

Background information

Have you been seen at Family Service of Roanoke Valley before? ☐ Yes ☐ No **If yes, how long ago?** _____

If no, have you had therapy in the past? ☐ Yes ☐ No **If yes, how long ago?** _____

What you would like to let a counselor know about why you are seeking services?
(Examples - job loss, recent death of friend, adoption, past trauma, sexual abuse, drug abuse, etc.)

_____

_____

_____