



# Legacy Family Services Inc.

## Client Referral Form

### Referral Guidelines

To refer a potential client, please complete this form and return it via email at [ashleybryant@legacyfamilyservicesok.org](mailto:ashleybryant@legacyfamilyservicesok.org) or fax (405) 376-1188.

### Referral Source Information

Name of referral source: \_\_\_\_\_ Date: \_\_\_\_\_

Agency/Program of referral source: \_\_\_\_\_ Email Address: \_\_\_\_\_

Phone Number: \_\_\_\_\_ Fax Number: \_\_\_\_\_

### Referral Information

Client's Name: \_\_\_\_\_

Gender:  Male  Female  Other \_\_\_\_\_

Date of Birth: \_\_\_\_\_

Primary language of client: \_\_\_\_\_

Is client in custody of the state:  Yes  No County of Jurisdiction \_\_\_\_\_  
If so, caseworker name and phone: \_\_\_\_\_

Is client in custody of the state:  Yes  No County of Jurisdiction \_\_\_\_\_  
If so, caseworker name and phone: \_\_\_\_\_

Social Security Number: \_\_\_\_\_

Parent/Guardian: \_\_\_\_\_

Address: \_\_\_\_\_

Insurance Company: \_\_\_\_\_  
Insurance Number: \_\_\_\_\_

Reason for referral: \_\_\_\_\_

### For Office Use Only

Date Received: \_\_\_\_\_ Contacted? \_\_\_\_\_