509 S Chickasaw Trail, 124
Orlando Florida 32825
Phone 321-972-1875
Fax: 407-315-0048

Journeys End Counseling Services Referral Form

Referral Source Information:

- **Organization Name:**_____
- **Contact Person:**_____
- **Phone Number:**_____
- **Email Address:**_____

Client Information:

- **Client's Name:**_____
- **Phone Number:**_____
- **Email Address:**_____

Therapy Needs:

- ☐ Reunification with Children
- ☐ Trauma from Domestic Violence
- ☐ Parent Enrichment via Parent Coaching
- ☐ Ongoing or Chronic Mental Health Needs and Diagnosis

Case Information:

Are the services court-ordered?

- ☐ Yes
- ☐ No

Is the client compliant with other case plan requirements?

- ☐ Yes
- ☐ No

Additional Family Therapy Information:

- ☐ **Will the client be required to participate in therapy with their child?**
  - ☐ Yes
  - ☐ No

List ages of children:

- ☐ **If yes, please provide the contact information for the child's caregiver:**

  Name:

  Phone Number:

  Email Address:

Has funding been approved? If so, authorization #_____

- ☐ Therapy
- ☐ Parent Coaching
- ☐ Parenting Group

Attachments:

Please attach any relevant case information and documents concerning the reason for the services, including any upcoming court dates.

Note: Journeys End Counseling is not a medicaid provider and services are provided via telehealth.

Email completed form to: jecounseling4u@gmail.com or fax to 407-315-0048

www.journeysendcounseling.com