# Metis Counseling Group Referral Form

**1515 W. Cornwallis Dr. Greensboro, NC 27408**
**Tel: (336) 937-3146 Fax: (336) 585-6269**

## General Patient Information

Client's Full Name _____ Date of Birth _____

Phone Number _____ Email_____

Diagnosis (if known): _____

Insurance Provider (if any): _____

## Referral Information

Referral Source: _____

Phone Number: _____ Email: _____

Date of Referral ____/____/____ Is patient aware of referral? Yes ☐ No ☐

If yes, is patient requesting treatment? Yes ☐ No ☐

Current mental health treatment? Yes ☐ No ☐
If yes, name of provider: _____

Previous mental health treatment? Yes ☐ No ☐
If yes, name of provider: _____

## Clinical Features (check all that apply)

- ☐ **Depressive symptoms**
- ☐ **Obsessive/Compulsive behaviors**
- ☐ **Anxiety/Panic**
- ☐ **Personality disordered symptoms**
- ☐ **Substance use**
- ☐ **Suicidal ideation/Self-harm behaviors**
- ☐ **Manic/Hypomanic symptoms**
- ☐ **Psychotic symptoms**
- ☐ **Major cognitive impairment**
- ☐ **Inability to cope with life stressors**
- ☐ **Long standing behavioral issues**
- ☐ **Other** _____