BLUE OAK COUNSELING SERVICES
TOGETHER WE CAN CREATE CHANGE

PATIENT REFERRAL FORM

FAX TO: (909) 510-8260
Questions: (909) 366-4712
3200 E. Guasti Rd, Suite 100
Ontario, CA 91761

Complete electronically or print clearly. Fax securely; please do not email completed forms.

01 REFERRING OFFICE

Referral date

Practice / organization

Referring clinician / contact

Office phone

Office fax

Contact role / title

02 PATIENT & CONTACT INFORMATION

Patient full name

Date of birth

Parent / legal guardian name (if applicable)

Relationship to patient

Best phone for patient / guardian

Preferred language / interpreter needs

Permission to leave voicemail: ☐ Yes ☐ No ☐ Not yet confirmed

Insurance plan / EAP or self-pay

Member ID (if available; do not include SSN)

03 REQUESTED SERVICES

☐ Child / play therapy ☐ Teen therapy ☐ Adult therapy ☐ Couples / family

Preference: ☐ In person (Ontario) ☐ California telehealth ☐ Either

Brief reason for referral / relevant needs (minimum necessary information only)

Referral does not guarantee placement. Intake will confirm fit, openings and insurance requirements.

04 REFERRAL & CONTACT CONFIRMATION

☐ Patient / authorized representative agrees to this referral and intake contact.

☐ Referring office has confirmed the legal basis and any required authorization for disclosure.

These checkboxes do not replace a required release of information or other legal authorization.

Completed by / title

Date

CONFIDENTIAL: Verify the fax number before sending. Send only information needed for the referral.

Not for emergencies. For immediate danger call 911; for crisis support call or text 988.