Greater Cincinnati
Behavioral
Health Services

Our Work is Life Changing

Referred BY: ______________________Phone #_________________

Client

Name: ____

Address____

Phone#____

Parent/ Guardian

Name: ____

(If different from above)

Address:____

Phone #____

Best time to contact: ____

Prefers _DAY _After 4pm for therapy session

Reason for referral **Is client thinking of hurting themselves? _yes __no**