House of Freedom

2311 N. OBT, Kissimmee, FL 34744
407.957.9077 office 888.702.0079 fax

Referral Form for Mental Health/Substance Abuse Treatment Services

Referring Agency: _____ Contact Person: _____

Phone No.: ( ) _____ - _____ Fax No.: ( ) _____ - _____ Email _____

Do you have a Release of Information to communicate with House of Freedom, Inc.? _____

Client's Name:_____ Gender: M F   Age: _____

Date of Birth: ___ /___ / ___   Social Security Number: _____-____-_____   Marital Status: _____

Address: _____ City: _____ State: ___ Zip: _____

Race/Ethnicity: _____ **Potential funding source**: _____

Preferred Contact Number: ( ) _____ - _____   home   work   cell

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Primary Caregiver's Name if Client is a Minor: _____

Date of Birth: ___ /___ / ___   Social Security Number: _____-____-_____   Marital Status: _____

Address: _____ City: _____ State: ___ Zip: _____

Race/Ethnicity: _____ Relationship to client: _____ Gender: M F   Age: _____

Name of all people living with the client	Age	Relationship to Client	Monthly Income
1			
2			
3			
4			
5			

Presenting Problem:

_____

_____

_____

_____

_____

Desired Treatment(s): Check all that apply

☐ SA Residential Treatment   ☐ 28-day Detoxification   ☐ Other Detox Services
☐ Dual Diagnosis Treatment   ☐ SA Outpatient Treatment   ☐ Mental Health Counseling
☐ Drug/Alcohol Evaluation   ☐ Psychosocial Rehabilitation ☐ Parenting Skills Group
☐ Substance Abuse Group   ☐ Anger Management Group   ☐ Family Program