Referral Date: ______________________________

Referral from: ______________________________

The Family Collective Counseling Referral Form

Through Catholic Charities, The Family Collective offers free, trauma-informed counseling for families that are receiving services through any partner organization of The Family Collective. Counseling is available to individuals, couples or families.

Please fill out contact information for the head of the household who is seeking counseling and fax or email to the contact person at the bottom of the form along with a completed Release of Information. Our staff will contact the family to review their needs and set up an appointment.

Last Name:		**First Name:**	
Cellphone:		**Other Phone:**	
Email:		**Interested in Telehealth Sessions:** Yes / No	
Current Address:		**Shelter:** ☐ **Friend / Relative:** ☐ **Own:** ☐	**In car:** ☐ **Motel:** ☐ **Rent:** ☐
Household Composition: *(Name, age and relation to head of household)*		**Client's ASSM Score:** ________ *Please fax or email the full ASSM assessment along with Referral Form and Release of Information Form.*	
Family's External I.D. Number: *(Located in Salesforce)*			

Why are you seeking counseling at this time?

Who are you seeking counseling for (self, whole family, child, etc.)?

Rate severity of current problems on a scale from 1 to 5
(1 being the least severe and 5 being more severe).

Rate severity of family stress on a scale from 1 to 5
(1 being the least severe and 5 being more severe).

What do you hope to gain from mental health counseling?

Is there anything else you want us to know?

Please fax or email this form to:

C/O Casey Kobosh
Catholic Charities of Middle Tennessee
The Family Collective
Fax: 615.352.8591
Phone: 615.719.2498
Email: ckobosh@cctenn.org

Diocese of Nashville Catholic Charities LOVE † HOPE HEALING

SIEMER INSTITUTE

TN Department of Human Services

United Way of Greater Nashville

Diocese of Nashville
Catholic Charities
LOVE † HOPE
HEALING

AUTHORIZATION FOR RELEASE OF INFORMATION

Re: Name: ______________________________ Date of Birth: ______________

Address: ____
Street City / State Zip

I hereby authorize ____
(Name of agency or individual)

____
(Address, City, State, Zip Code)

and its physicians, employees and agents to release or disclose to/from ____________________ with

Catholic Charities of Tennessee, Inc., 2806 McGavock Pike, Nashville, TN 37214
(Address, City, State, Zip Code)

all of my medical records including any specifically protected, such as those relating to psychological impairments, drug abuse, alcoholism, sickle cell anemia, or HIV infection. Documents authorized for disclosure include:
(Initial approved items)
______ (1) Medical history, examination, laboratory tests and treatment reports
______ (2) Psychological test reports
______ (3) Psychiatric evaluation reports
______ (4) Social history data including family, education, employment and other relevant material
______ (5) Summary of previous mental health and/or counseling services
______ (6) Periodic reports of current treatment progress including attendance and participation
______ (7) Notification of referral source of initiation and termination of counseling
______ (8) Specify: ____

I understand that this information will be used for the following specific purposes:
(Check ALL items)

YES NO
______ ______ (1) To develop an assessment, counseling, casework, and/or adoption plan
______ ______ (2) To coordinate medical, psychological and social rehabilitative processes
______ ______ (3) Specify: ____

I understand no information may be re-disclosed by either agency to any other individual or agency unless by my written consent. I therefore authorize the release/disclosure of the following documents *(Initial approved items)*:

______ 1. Only records generated by the above-named provider (not including records received from other sources).
______ 2. Only a portion of the records maintained by the above-named provider (dates of treatment, etc.)
Please specify: ____
______ 3. All records at this facility.

You may revoke this consent to release personal, educational and protected health information at any time, by written request. Unless you revoke it, this authorization shall remain in effect for one year or until such time as specified herein:
____

I understand that information used or disclosed pursuant to the authorization may be subject to re-disclosure by the recipient of your protected health information and no longer by the HIPAA Privacy Rule. This consent for release of information is given freely, voluntarily, and without coercion.

____
Signature of Client Date Signature of Case Manager Date

____
Signature of Responsible Party for Minor Relationship