Cognitive Connection Corporation

Referral Form
(Please Print or Type)

THE COGNITIVE CONNECTION

Please send this form to Tim Cook
Fax: 828-256-3623 or Email: tcook@thecogcon.com

Client Name:	DOB:	SSN: XXX– XX–	Gender: M ☐ F ☐
Hispanic/Latino: ☐ Race:	School/Grade:		
Legal Guardian Name/Relationship to Client:			
Phone Number:	Guardian Phone Number:		
Physical Address:	City:	Zip:	
Mailing Address:	City:	Zip:	

Additional Client Information:		
Does the Client Speak English? Yes ☐ No ☐ What is the primary language spoken in the household?		
Does the Client have an Exceptional Designation? (EC or IEP) Yes ☐ No ☐		
Is the Client currently receiving counseling services? Yes ☐ No ☐ If yes, where?		
List any current medical problems:		
List all current medications:		
Does the Client have private medical insurance? Yes ☐ No ☐ If Yes, Policy Number:		
Does the Client have Medicaid/Health Choice? Yes ☐ No ☐ If Yes, Policy Number:		
If "no", has parent/guardian applied for Medicaid or Health Choice? Yes ☐ No ☐		
Enter the number of problems the client has experienced over the previous 12 months:		
Number of Runaways		☐ Unknown
Number of Short-Term Suspensions		☐ Unknown
Number of Long-Term Suspensions		☐ Unknown
Number of Expulsions		☐ Unknown
Additional Comments:		

Name of Person Making the Referral:	
Title:	
Phone Number:	Email:
Date of Referral: (MM– DD– YYYY)	
Describe the reason why you're referring this client to this program:	
Date the referral is received by the program: (MM– DD– YYYY)	