FEEDBACK TO REFERRAL SOURCE

Whenever possible, and with clients' written permission, I like to thank individuals for referring a client to me, and notify the referral source when a client has followed through with his/her recommendation to seek therapy or medication evaluation. Please check one of the following, complete the information (if granting consent) and sign where indicated.

☐ I, _____authorize Shauna Norton, APRN to contact_____to notify him/her that I have scheduled and kept an initial appointment for treatment services.

☐ I do not authorize Shauna Norton, APRN, to contact the person who referred me to treatment, or not applicable.

Referral Information

Name:_____

Address:_____

Phone:_____

Fax:_____

_____

Signature of Client Date

_____

Signature of Parent/Legal Guardian Date

_____

Witness Date