



EBONY HORSEWOMEN, INC.

337 Vine Street, Hartford, CT 06112
(860) 293-2914 Email:
info@ebonyhorsewomen.us
www.ebonyhorsewomen.us

A Mind's Journey, LLC

1339 Albany Ave, First Floor
Hartford, CT 06112
860.263. 8021
www.amindsjourney.org

REFERRAL FORM

Referral Date: _____
Interpreter Required. Yes No

CLIENT DETAILS:

Name: _____ Gender: _____ DOB: _____

Age: _____

Ethnicity: _____

Address: _____

Phone: Home: _____ Mobile: _____ Work: _____

Caretaker/Guardian#1: Caretaker/ _____ Relationship: _____
Guardian#1: _____ (Phone No.) _____ Relationship: _____

Address (if different from above): _____

Emergency Contact: Name: _____

Phone: _____

Insurance: Carrier & Policy#: _____

Effective Date: _____

Referral Source: Name: Position/Title: _____

Organization: _____

Email address: _____

Phone: Office _____ Mobil: _____

Address: _____ City: _____ State _____ Zip: _____

Is client aware of the referral? Yes or No

If not, please give reason _____

Did the client agree to the referral? Yes _____ or No _____

If not, please give reason _____

Family violence concerns. Yes _____ or No _____

Any safety risks for visitors. Yes _____ or No _____

If yes, please provide type of risk(s) involved _____



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Other health professionals/agencies involved. (Please specify)

Please list all known Psychiatric Hospitalizations, Crisis Visits or Risk Assessments that have occurred in the past year:

Hospitalization(s)	Date of Occurrence

Reason for Referral: (please check all that apply):

- | | |
|--|-------------------------------------|
| Counseling _____ | Trauma _____ |
| Individual Therapy (Adult & Child) _____ | Grief and Loss _____ |
| Family Therapy _____ | Domestic Violence _____ |
| Couples Therapy _____ | Equine Assisted Psychotherapy _____ |
| Group Therapy _____ | Anger Management _____ |
| CBT/DBT _____ | |

Other significant information/Summary: (please attach separate sheet if necessary):

Email to: awashington@amindsjourney.org or rellisdenby@amindsjourney.org

Date received: (office only)

Referrals can be made by GP, allied health provider, agency, self-referral or family member.

If we are unable to provide a service, we will endeavor to notify client/referrer of other appropriate services. Referrals can be received by phone, fax, mail or email detailed as above.

