PeaceWay CMS
Counseling & Mediation Services, Inc.

"Helping to put the pieces together"

Non-Medicaid Referral Form

Referral Date: _____/_____/_____

Indicate type of service:

- ☐ Individual Therapy __
- ☐ Family Therapy
- ☐ Anger Management (12 wks)
- ☐ Anger Management Adolescents (8 wks)
- ☐ Civil Mediation __Arbitration
- ☐ Pre-Marital Counseling __
- ☐ Parenting Support (8 wks)
- ☐ Domestic Violence (FVIP 24wks)
- ☐ Domestic Mediation
- ☐ Marital Counseling
- ☐ Substance Abuse Treatment (17 wk)
- ☐ Substance Abuse Education (7 wk)

Client Name:_____ _____ _____
(First) (Middle) (Last)

Date of Birth: _____/_____/_____ Social Security Number :_____-_____- _____

Marital Status:_____ ☐ Male ☐ Female

Street Address:_____ _____ _____
(City) (State) (Zip)

Home Phone:_____Cell :_____Work :_____

Employer:_____ Email: _____

Work Address:_____ _____ _____
(City) (State) (Zip)

Referring Agency: _____

Agency Contact Person: _____ Phone Number: _____-_____- _____

SIGNATURE:_____

Accepted for PeaceWay CMS by: _____