

Counseling Center of Montgomery County

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REFERRAL AND CONSENT TO RELEASE INFORMATION

From: Treehouse Center

To: Counseling Center of Montgomery County

Name of Client:		Gender: Male Female	
Address:			
City:		State / Zip:	
Cell Phone:	Home Phone:	Work Phone:	
Email Address:		Date of Birth:	Age:
Social Security #:		Medicaid #:	
Referring Staff Member:			
Email Address:		Phone Number:	

Requested Services:

Group Therapy	(please circle all that apply)	Assessments	
Substance Recovery		Substance / Alcohol Abuse	
Alcohol Recovery		Anger Management	
Anger Management		Diagnostic Review	
Productive Parenting		Mental Health Evaluation	
Conflict Resolution		Other:	
Divorce Recovery (Adults / Teens / Kids)		Counseling Services	
Coping Skills		Individual	
Blending Your Family		Group	
Healthy Relationships		Family	
Boys Group			
Girls Group			
Teen Talk			

I authorize exchange of information between the The Treehouse Center and the Counseling Center of Montgomery County during the term of my residence.

Client Signature

Date

Staff Member

Printed Name

Date

Supervisor

Printed Name

Date