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COUNSELING, LLC

EMDR Referral

Date of Referral:_____

Referring clinician:_____

Date of consult:_____

Client Name:_____ **Client DOB:**_____

Reason for Referral to treatment:_____

_____

_____

Diagnosis (please include any previous diagnosis)_____

_____

Current medications: _____

Date of Intake to Be Inspired:_____

Reason for referral for EMDR:_____

_____

_____

_____

Previous EMDR treatment:_____

_____

_____

_____

Preferred treatment modalities (DBT,CBT,ACT,MI,etc.)_____

_____

_____

Symptoms:_____

247 Washington Street, Second Floor - Stoughton, Massachusetts 02072
44 Wood Avenue, Unit 1A - Mansfield, Massachusetts 02048
P: (508) 930-0154 F: (781) 634-0086
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Contributing factors to symptoms:_____

Dissociation concerns: (DES-Y/N)_____

Current safety concerns:_____

Substance use concerns, current or prior to treatment: _____

Issues related to religious influences:_____

Issues related to gender identity/sexual preference:_____

Cultural considerations:_____

Identified strengths: _____

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