Healing Hoofbeats of CT, Inc.

Phone: (860) 459-4115 www.healinghoofbeatsofct.org

Referral Form- Operation Warrior Horse

Date: _____

Client Name: _____ DOB: _____ Age: _____

Gender: _____ Culture/Ethnicity: _____

Address: _____

Phone Number: _____ Can a message be left? Y N

Branch of Service: _____ Active Reserve Inactive

Date of Discharge: _____ Honorable Other

Highest Rank: _____ Area of Training: _____
Are you a combat veteran? Yes No

Theater of Operation: _____ How many years of active duty? _____

Were you wounded while serving? Yes No
If yes, please explain: _____
_____

Emergency Contact: _____ Phone: _____

Referral Source: _____ Phone: _____

Name of worker: _____ Title: _____

Phone: _____

Presenting Problem: _____
_____
_____
_____

Services Requesting: _____

Previous Mental Health Provider(s): _____

Suicidal/Homicidal/Aggressive/Risky behaviors of concern: _____
_____

Please send back to Renee Bouffard, LCSW via:
Mail: 41 Judge Ln, Bethlehem, CT 06751
Email: healinghoofbeatsllc@gmail.com
Fax: (860) 733-0323