

**Outpatient Clinic Services
Group Therapy Referral**

Date: _____

Referred Person's Name: _____

Person Making Referral: _____

Address: _____

Relationship/Agency: _____

DOB: _____ Phone # : _____

Group being referred to:

_____ Healthy Relationships (Fall Session)

_____ Anger Management/Stress Management (Spring Session)

Does the person have any behavioral issues? ___Y ___N

Do they have a BMP? ___Y___N (please attach)

If yes, please explain:

Does the person have any sexuality or relationship issues? ___Y ___N

If yes, please explain:

Reason for referral/Specific goals for the group:

**Please Return To:
CP Rochester
Attn: Connie Mastowski
3399 Winton Road South
Rochester, NY 14623**