TAPNET REFERRAL DOCUMENTATION

Date of Referral: _______________

PERSON REFERRING COUNSELOR

First Name: ___________________________ Last Name: _______________________________

Title: ____

Employer: ____

Facility Address: ____

City/ State/ Zip: ____

Telephone: ____

Relationship to Counselor: ____

COUNSELOR BEING REFERRED

First Name: ___________________________ Last Name: _______________________________

Address: ____

City/ State/ Zip: ____

Telephone: _______________________________ SSN#: ________________________________

License #: ____ Expiration Date: _______________

Title: ____

DOB: ____ Sex: _____________________________

Job Status When Referred: Employed ________ Terminated _________ Suspended __________

Length of Employment: ____

Type of Employment: ____

Current Area of Practice: ____

Reason for Referral: CD___________________________ Mental Illness____________________

Description of possible practice violations (be specific, add additional pages as needed): ______

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Form Completed By: _______________________________________ Date: _________________

Contact TAPNET

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peerassistance@taap.org