

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): _____

Form Completed By: _____ Date: _____

Contact TAPNET

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