# The Brookline Center

## Adult Group Psychotherapy Referral Form

41 Garrison Rd. Brookline, MA 02445

**Phone:** (617) 277-8107 ext. 186 **FAX:** (617) 734-6385

**REFERRING CLINICIAN:** **Date:**

**Phone Number:** **Email:**

**Best Time to be Contacted:** **Current Treatment Facility:**

**CLIENT INFORMATION:**

**First Name:** **Last Initial:** **Phone #:**

**Address:**

**Age:** **Gender:** **Relationship Status:**

**Occupation:** **Insurance:**

**CURRENT TREATMENT STATUS:**

**Therapist:** **Psychiatrist:**

**Hospitalization/PHP: Dates** **Medications:**

**Treatment Focus:**

**Why is the client seeking group treatment at this time?**

**What are their goals in group treatment?**

**Current life situation:**

**Prior Group Experience:**

**What are your questions about our groups?**

**CONFIDENTIALITY NOTICE**

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