The Community Lighthouse, Inc.
Serving the community since 1994

3301 Candelaria Rd. NE suite B
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Tel. 505.273.6300
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Referral Form

Patient Information

Patient Name: ___________________________________Date of Birth_________________________

Parent(s)/Guardian(s) (if applicable) ____

Phone Number___________________Alternate Number______________________ Email_______________

What service(s) are you referring for? (Circle any that apply)

Therapy **BMS Service** **Family Therapy**

Any additional concerns? ____

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Axis I Diagnosis (if known):____

Name of individual making referral ____

Referring Practice ____

Phone number_______________________

Signature____________________________Date_____________________________

Please fax (505) 265-7680. Please call us at (505) 273-6300 with any concerns. Thank you!