

**Couples Therapy Clinic**  
**Referral Form**

**Patient Name:**

MR #:

**Age:**

**Name of Partner:**

**Age:**

**Check to verify time that the couple can attend together:**

Monday 4PM

**Have they spoken with their partner about attending couples therapy at our clinic?**

Yes  No

**Have they been informed that they may be observed by other couple therapy clinicians and students?**

Yes  No

**Reason for referral:**

**Patient's Stated Goal for Therapy:**

**Partner's Stated Goals for Therapy:**

**Co-Morbid Psychiatric Dx(s):**

**Safety Issues for This Couple (Domestic Violence, SI, HI):**

**Patient Contact Information:**

**Referred by:** \_\_\_\_\_ **Date:** \_\_\_\_\_