Valliere & Counseling Associates, Inc.

Forensic Treatment Services

Treatment Referral Form

Referring to (please check one):

[ ] *Valliere & Counseling Associates* – referral for treatment/evaluation of children, adolescents, victims of abuse, and general mental health or adjustment difficulties. Protective parenting and non-offending parent treatment available.

Location: **726 Church Street, Fogelsville, PA 18051**
Phone: (610) 530-8392 Fax: (610) 530-8940

728 West Turner St., Allentown, PA 18102
Phone: (610) 351-0138 Fax: (610) 289-4883

[ ] *Forensic Treatment Services, a division of Valliere and Counseling* – referral for treatment of adult and adolescent who are sexual offenders, sexually aggressive, domestically violent, or abusive. Individual and group treatment available as well as Polygraph services.

Location: **732 West Turner Street, Allentown, PA 18102**
Phone: (610) 433-1529 Fax: (610) 289-4883

Name of Client: _____ DOB: _____ Age: _____

Contact Name and Number: _____

Reason for Referral/Referral issues: _____

_____

_____

(Please forward a referral package, with referral questions, prior evaluations, court summaries, and allegations when possible, prior to the client's first appointment. We will contact the casework or client after we receive the package).

Services Sought: _____ Treatment (Individual)
(check all that apply) _____ Treatment (Group)

Name of Referring Agent/Caseworker: _____
Agency: _____ Phone #: _____ Email: _____

Is your Agency funding treatment? [ ] YES (please request authorization and send us a copy)

[ ] NO, explain funding source: _____

Is this court mandated? YES [ ] NO [ ]

Are there other agencies involved with this client we should contact? [ ] NO [ ] YES
Please list: _____