**Revised 09/09**

# MENTAL HEALTH REFERRAL

**NAME:**_____

As a condition of your supervision, you are to participate in a mental health program. To arrange an intake/orientation. you must contact the below listed agency on _____.

CORNERSTONE COUNSELING MENTAL HEALTH
312 NE 28TH Street #101
Oklahoma City, OK 73105
(405) 231-3150

[ ] Mental Health Assessment
[ ] Mental Health Counseling
[ ] Family Mental Health Counseling
[ ] Emergency Financial Assistance
[ ] Emergency Financial Assistance Administrative Fee
[ ] Copayment Assessed $_____
[ ] Medication Management
[ ] Group Mental Health Counseling
[ ]Case Management

I acknowledge that I have read and understand the matters stated in this document and have received a copy.

_____ _____

NAME DATE U.S. PROBATION OFFICER DATE