Revised 08/06

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 _____.

OPTIONS COUNSELING SERVICE, INC.
420 W. Country Club
Suite 2
Chickasha, OK 73018
(405) 222-3018

[ ] Mental Health Assessment
[ ] Mental Health Counseling

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