BECT SERVICES
"Providing Support For Change"
www.bect-services.com

Behavior Education Consultation & Training Services LLC

Email completed form to: info@bect-services.com

Referral/Intake Form

Date of Referral: _____ **Case Number:** _____

DHR Worker: _____ **DHR Worker office #:** _____

DHR Worker Supervisor: _____

Name:_____ **Date of Birth:** _____

Address: _____

Phone: _____ **Wk Phone:** _____ **Alt Phone:** _____

Reason for Referral:

_____

_____

_____

Outcomes Desired:

_____

_____

_____

Services requested:

○ **Family Support:** **Frequency:** **Weekly** **Bi Weekly** **Monthly** **Other**

Duration: **30 min** **45 min** **1 hour** **2 hours**

Client(s)_____

○ **Basic Living Skills:** **Frequency:** **Weekly** **Bi Weekly** **Monthly** **Other**

Duration: **30 min** **45 min** **1 hour** **2 hours**

Client(s)_____

Office Location: 696 North Silver Hills Drive Suite 108 & 110 Prattville, AL 36066
Mailing Address: P. O. Box 680162, Prattville AL 36066
Office Phone:334-380-9797 Cell Phone: 256-452-8504 Fax Phone: 334-380-9799

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○ **Individual Counseling:** **Frequency:** **Weekly** **Bi Weekly** **Monthly** **Other**

Duration: **30 min** **45 min** **1 hour**

Client(s)_____

○ **Fam. Coun. w/o child:** **Frequency:** **Weekly** **Bi Weekly** **Monthly** **Other**

Duration: **1 hour**

Client(s)_____

○ **Fam. Coun w/ child:** **Frequency:** **Weekly** **Bi Weekly** **Monthly** **Other**

Duration: **1 hour**

Client(s)_____

Does the client AGREE to services? ( ) YES ( ) NO

_____ _____

Referral Person **Date:**

PURCHASE ORDER AUTHORIZING SERVICES MUST BE RECEIVED PRIOR TO THE IMPLEMENTATION OF ANY SERVICES

DO NOT WRITE BELOW THIS LINE

Case Accepted ( ) Yes ( ) No If not, Reason: _____

Date Initial 1878 Received: _____

_____ _____

Representative Signature Date

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