Sky Riding Long Island

Equine Facilitated Psychotherapy
Referral Form

Client Name: _____ DOB: _____ Age: _____

Address: _____ Phone: _____

Diagnosis: _____

Recommended Frequency and Duration of Sessions: _____

_____

_____

Type of Format: ___ Group Work ___ Individual Work _____ Family Work

Specific issues to address:

Current treatment goals:

Additional information:

_____ _____

Mental Health Professional Date

_____ _____

State Credentials/License # Phone & Fax Numbers

_____ _____

Address

Mail form to: Christa Schorn 63 Tompkins Street, East Northport, NY 11731 or email pdf version to cschorn@optonline.net

Thank You for Your Participation and Referral