



Aerie Art Therapy Services

Natural • Expressive • Safe • Transformative

Referral Form

Client Name: _____

Date of Birth: _____

Client Address: _____

Caregiver Name: _____ Relationship: _____

Phone: _____

Referred by: _____ Title: _____

Agency: _____

Requested Services

Individual Art Therapy

Family Art Therapy

Group Therapy

Reason for Referral: