



When complete, return to appropriate recipient

Workshops- workshops@trinity-ec.com

Community Connections- communityconnections@trinity-ec.com

Equine Services- equineservices@trinity-ec.com

Psychotherapy- equineservices@trinity-ec.com

Youth Counseling- youthcounseling@trinity-ec.com

Trinity Equestrian Center – New Client Referral Form 2025

Client Information

Referral Date _____

First Name _____ Preferred Name _____ Last Name _____

Date of Birth ____/____/____ Age _____ Gender _____ Race _____ Pronouns _____

Address _____ City _____ State _____ Zip Code _____

Phone Number _____ Email _____

Where is the client/child currently living? ____ Home ____ Home of a Relative ____ Foster Care ____ Other

School Attending _____ Grade _____ Has an IEP? ____ Yes ____ No

Client's Avatar Number _____ Client's MCI Number _____

Availability for services (daytime, afternoon, etc.) _____

Family Information

____ Spouse ____ Parent ____ Legal Guardian Name _____

Address _____ City _____ State _____ Zip Code _____

Phone Number _____ Email _____

Reason For Referral

Mental health and medical diagnoses _____

History of suicidal tendencies/self-harm ____ Yes ____ No If yes, please explain _____

History of danger to others/animals ____ Yes ____ No If yes, please explain _____

Goals for Participation _____

Additional Information

Is the client continent of bowel and bladder? ____

Has the client presented with problem sexual behavior? ____

Does the client understand verbal prompts and is able to communicate? ____

Has the client demonstrated physical aggression toward any professional in the last three months? ____

Please provide additional detail here _____

Referring Agency

Referring Agency _____ Contact person _____
Phone Number _____ Email _____

What Trinity Equestrian Center services are you interested in?

☐ Equine Assisted Psychotherapy
☐ Psychotherapy
☐ Adaptive Riding (Weight limit 190 pounds)
☐ Equine Workshops (Weight limit 190 pounds)
☐ Workshops
☐ Community Connections (ages 13-25)
☐ Youth Counseling; how many hours per week are you authorizing? ____ Hours

How will these services be paid for?

☐ WPS
☐ CCS
☐ County
☐ LSS
☐ IRIS
☐ Premier
☐ Other _____

***In order to proceed with scheduling an intake and services, a service authorization, Individual Service Plan with detailed goals and complete billing information must be provided to Trinity Equestrian Center's Administration. Thank you!**

Billing Agency

Name _____ Contact Person _____
Address _____ City _____ State _____ Zip Code _____
Phone Number _____ Email _____