



MAINSRING

WELLNESS & COUNSELING

The following individual has been referred to participate in services at MWC. The individual has been instructed to reach out to schedule an intake session.

NAME: _____ DATE: _____

PHONE: _____ INSURANCE TYPE: _____

☐

SUBSTANCE ABUSE GROUP (IOP)

The Mainspring IOP is an evidence-based, 12-week therapeutic group. The group will engage in three, 3-hour group sessions weekly.

☐

DOMESTIC VIOLENCE PROGRAM (BIP)

The Mainspring domestic violence program is a psycho-educational group addressing mental health and intimate partner violence.

☐

FOUNDATIONS FOR LIVING (ANGER MANAGEMENT)

The Mainspring FFL program is an evidence-based psycho-educational group addressing anger and other emotion regulation concerns.

☐

INDIVIDUAL MENTAL HEALTH COUNSELING

Evidence-based treatment for those experiencing issues related to:

- *Anger Management*
- *Abuse / Neglect*
- *Relationship Conflict*
- *Anxiety*
- *Parenting*
- *Trauma*

REASON FOR REFERRAL: _____

REFERRED BY: _____

NOTE: Referral forms can be faxed or sent via email to the fax/email listed below. MWC will reach out to client to establish services if contact information is provided.