DHA DAVID HOY & ASSOCIATES
Therapeutic Counseling | Change Your Mind

Date: __________ Referring Worker Name: ____________________________________

Referring Agency:__________________________ Relationship to Client:____________

Phone: __________________________________Fax:____________________________

Client Name: _______________________________________ **DOB**: ______________

Guardian (s) Name (s) & Relationship to client (for minor clients):

____

Address: _________________________________ Phone: _______________________
_________________________________ Cell: _________________________

Gender: _____ Culture/Ethnicity: _________ Primary Language/ESL: _________

Insurance Provider ______________________________ MA/PMAP/Private (circle one)

ID#__________________________________ Group #___________________________

Services Requested (circle all that apply): Outpatient Therapy – In-home Therapy – In-home Family Therapy – Individual Skills – Family Skills

Location: Golden Valley ______ Chaska _____ Hutchinson______ (In-home Only) New Brighton______

Client Availability: M: _______ T: _______ W: _______ Th: ______ F:________

Psychiatrist/Physician Name: ____

Other Service Providers: ____
Name Phone

Family Information: ____
____

Reason for Referral/Specific Concerns: ____
____
____
____

Staff Requested: ____

***Please fax the following information to 763-544-1008, Attn: Sara Hensche**

- This form, completed
- Release of information
- Current Diagnostic Assessment – if there is not a current Diagnostic Assessment check this box ☐