DHA DAVID HOY & ASSOCIATES
Therapeutic Counseling | Change Your Mind

Date: ____________
Referring Person's Name & Relationship to client:_______________________________
Referring Agency/Source:____
Phone: __________________________________Fax:____________________________

Client Name: ______________________________________ **DOB**: ______________

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

All Parents/Guardians involved & Relationship to client (for minor clients):

____

Address: _________________________________ **Phone:** ______________________
_________________________________ **Phone**:_______________________

Is it okay to leave a voice mail at these phone numbers if you are not able to answer? **Y/N**

Insurance Provider:___________________________ **MA/PMAP/Private (circle one)**
For Private Insurance clients: Would you like us to call you back with a benefit explanation after we verify coverage? **Y/N**

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______ New Brighton_____
(In-home Only)

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

Current Mental Health Diagnosis:____

Other Mental Health Providers: ____
Name Phone

Family & Household Information (Include Pets): _____________________________
____

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
- **Most Recent Diagnostic Assessment – if there is not a current Diagnostic Assessment check this box** ☐