

Date: _____
Referring Person's Name & Relationship to client: _____
Referring Agency/Source: _____
Phone: _____ Fax: _____ Email: _____

Client Name: _____ **DOB:** _____

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

Parent/Guardian: _____ Email: _____

Address: _____ **Phone:** _____
_____ **Phone:** _____

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

Is it okay to send text appointment reminders to this number? **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

In-home/Skills services are only covered by MA or PMAP Plans

Location: Golden Valley _____ Chaska _____ Telehealth _____

Client Availability: M: _____ T: _____ W: _____ Th: _____ F: _____

Current Mental Health Diagnosis: _____

Other Mental Health Providers: _____

Name

Phone

Are Mental Health Services Court Ordered? If yes, what was the offense? Y/N

Offense: _____

Family & Household Information (Include Pets): _____

Reason for Referral/Specific Concerns: _____

Staff Requested: _____

***Please fax the following information to 763-544-1008, Attn: Admin Staff**

- This form, completed
- Release of information
- Most Recent Diagnostic Assessment – if there is not a current Diagnostic Assessment check this box**
- Due to the Covid-19 outbreak, we are providing primarily telehealth therapy (online video counseling), with limited availability for in person therapy.**