DHA DAVID HOY & ASSOCIATES
Therapeutic Counseling | Change Your Mind

REFERRAL FORM

Date: _____

Referring Person's Name & Relationship to client:_____

Referring Agency/Source: _____

Phone: _____Fax:_____Email:_____

Mental Health Case Manager Name: _____ Company:_____

Phone: _____Fax:_____Email:_____

CLIENT INFORMATION:

Client Name: _____ DOB: _____

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

Home Address: _____

Phone: _____ Email: _____

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

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

GUARDIAN INFORMATION:

Name: _____ Relationship: _____

Phone: _____ Email: _____

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

Name: _____ Relationship: _____

Phone: _____ Email: _____

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

*Circle which phone number should receive text message appointment reminders:

INSURANCE INFORMATION:

Primary Insurance Provider: _____MA/PMAP/Private (circle one)

ID#_____ Group #_____Insurance Company Phone #:_____

Policy Holder Name: _____ DOB: _____ Employer: _____

Policy Holder Mailing Address: _____

Policy Holder Phone Number (if not listed above):_____

Secondary Insurance Provider: _____MA/PMAP/Private (circle one)

ID#_____ Group #_____Insurance Company Phone #:_____

Policy Holder Name: _____ DOB: _____ Company: _____

Policy Holder Mailing Address: _____

Policy Holder Phone Number (if not listed above):_____

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REFERRAL FORM
SERVICE REQUESTED

Type of service (circle all that apply):

In-Office Therapy/Virtual 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 (circle all that apply): Golden Valley/Chaska/In-Home/Virtual

Availability (include time of day)						
Monday	Tuesday	Wednesday	Thursday	Friday	Saturday	Sunday

OTHER INFORMATION:

Current Mental Health Diagnosis:_____

Other Mental Health Providers: _____

Name Location Phone

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

Reason: _____

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** ☐