Received by: ________________ Date: ______________________

11800 Aberdeen Street, Suite 100
Blaine, MN 55449

5200 Willson Road, Suite 440
Edina, MN 55424

Phone: 763-270-0054 // FAX: 763-208-6371

Therapy Connections Referral Form

Services Requested: ☐ **CTSS/Skills Services**
☐ **Outpatient Psychotherapy**: ☐Individual ☐Family

Urgent? ☐ Yes ☐ No (Explain: ____)

Referral Source: ______________________________ Title: ___________________________
Phone: ___________________ FAX: _____________________

Are you receiving any other services? ☐ Residential Treatment ☐ CTSS/In Home ☐ Outpatient
☐ Other ___________________________

Current Social Services/Court Involvement: ☐ Yes ☐ No If yes, explain: ______________________

Reasons for referral (Specific issues to address): ____
____
____

Therapist/Skills worker requested: ____
Therapist/Skills worker assigned: ____

Client/Patient Information:

Name: ________________________________ Age: ________ DOB: ___________________
Gender: ☐ Male ☐ Female
Client DX: ____
Medication(s): ____
Address: ____
Home Phone: ________________________ Work/Cell Phone: ___________________________

Parent/Caretaker Information:

Mother's Name and Address: Father's Name and Address:
___________________________ ___________________________
___________________________ ___________________________

Custody Status: ____
Members of family or others living in the home:
____

Financial Responsible Party/Insurance Information:

Medical Assistance Policy Number: _______________________
PMAP or Secondary: ________________ Policy # ___________________ Group #_____________
Policy Holder: ________________________________ DOB: __________________________
SSN (if MA): ________________________

Will these services be part of a county contract? ☐Yes ☐ No
Please specify terms: ____