DATE:

ADULT, CHILD & FAMILY SERVICES, LLC

REFERRAL FORM

REFERRAL SOURCE (AGENCY/PERSON):_____

Phone: _____ Fax: _____ Email Address:_____

Clients Name: _____ DOB: _____ GENDER: _____

Phone Number:_____ SOC. SEC. # _____

Address: _____

Parent/Guardian/ Spouse Name: _____

If Guardian, Explain Relationship:_____

Phone Number:_____

Case Manager ? Yes____ No____

Name:_____ Email address:_____

Prior or current treatment/ placements: _____

Contact Information:_____

Has A Current DA completed**?** If so, Date completed _____

REASON(S) FOR REFERRAL (check all that apply)

Outpatient Services:

□ Diagnostic Assessment
□ Other Assessment
□ Individual Psychotherapy
□ Couples Therapy
□ Crisis Therapy
□ EMDR
□ Sexual/Behavioral Health Program (SO)
□ Family Therapy
□ Other:_____

Brief Description of the Problem (attach separate sheet if necessary. please forward medical & behavioral information, court reports, social summaries, previous DA's, etc.)

_____

_____

_____

Billing Information

Primary Insurance: _____

Policy # _____ Group # _____

Does client have any other form of insurance? Yes/No If so, _____

Please **fax** this completed form to 507.344.1726 or **email** to kcooper@acfsmankato.org

Ver. 05/26