



RIVERSIDE COUNSELING

REFERRAL FORM

Like a River, Healing Moves Forward

REFERRING PROVIDER / AGENCY

Provider / Agency Name: _____

Contact Person: _____

Phone / Fax: _____ / _____

Email: _____

CLIENT INFORMATION

Client Name: _____

Preferred Name: _____

Date of Birth: _____

Phone: _____

Email: _____

Address / City / ZIP: _____

Preferred Contact: ☐ Phone ☐ Text ☐ Email

REFERRAL INFORMATION

Reason for Referral: _____

Primary Concerns / Goals: _____

Diagnosis, if known: _____

Current Services / Providers: _____

Urgency: ☐ Routine ☐ Time-sensitive ☐ Other: _____

SERVICES / PREFERENCES

☐ Individual Therapy	☐ Couples / Family Therapy
☐ Trauma-Focused Therapy	☐ EMDR
☐ Brainspotting	☐ Somatic / Nervous-System Work
☐ Anxiety / Depression	☐ ADHD / Neurodivergence
☐ Substance Use / Recovery	☐ Other: _____

INSURANCE / PAYMENT

Payment Type: ☐ Private Insurance ☐ MN Medical Assistance ☐ Self-Pay

Insurance Plan: _____

Member ID (optional): _____



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ADDITIONAL INFORMATION

REFERRAL / RELEASE

By submitting this referral, the referring party confirms that the client has been informed of the referral and that any required authorization or release of information has been obtained. Please do not include unnecessary sensitive information. Riverside Counseling will contact the client regarding scheduling and intake.

Referring Provider Signature:

Date:

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