Riverside Counseling

Professional Referral Intake Form

517 NW 4th St Suite 113B
Brainerd, MN 56401

Email: Anna@RiversideBrainerd.com
Fax: 763-220-6025
Phone/Text: 218-450-8600

Client Information

Client Full Name: ____________________________________

Date of Birth: ____________________________________

Phone Number: ____________________________________

Email Address: ____________________________________

Preferred Contact Method: ____________________________________

Referral Source Information

Referring Provider Name: ____________________________________

Agency / Practice: ____________________________________

Phone Number: ____________________________________

Email: ____________________________________

Relationship to Client: ____________________________________

Reason for Referral

Primary Concerns: ____

Clinical Summary: ____

Risk / Safety

Risk Concerns: ____

Urgency Level

Routine / Moderate / Urgent

Insurance / Payment

Insurance Type: ____

Provider: ____

Consent

I confirm appropriate consent has been obtained for referral and information sharing.