

School-Based Therapy Intake/Referral Form

DATE OF INTAKE/REFERRAL

Date: _____ School Location: _____

STUDENT INFORMATION

Student Name: _____ Date of Birth: _____ Grade Level: _____

Legal Gender: _____ Address: _____

Student Race/Nationality: _____

We ask to ensure we provide the best
care & support based on the clients
lived experiences and cultural identity.

Parent/Guardian Name (1): _____ Phone: _____

Parent/Guardian Name (2): _____ Phone: _____

Best Email(s) for Required Forms: _____

Emergency Contact For Student (Name, Relationship and Number)

Contact Details of Person Making Referral For Student (if you are not student guardian):

PRIMARY FUNDING SOURCE

Student insurance information is required, as school-based therapy is billed per appointment like other healthcare services. Please check with your insurance company for co-pay, deductible, or other cost for therapy.

Policyholder's date of birth is needed to verify insurance. If on a parent's plan, please provide parent name and date of birth.

Policy Holder Name: _____ DOB: _____

Insurance Name: _____ Policy ID # _____

Group # _____ PMI (if applicable) _____

If the student has more than one insurance plan, please list additional plan(s) below. We are required to verify all coverages.

Policy Holder Name: _____ DOB: _____

Insurance Name: _____ Policy ID # _____

Group # _____ PMI (if applicable) _____

CONTACT US: VEEMAH CONSULTING

EMAIL: INFO@VEEMAHCONSULTING.COM

OFFICE: 763-202-4767 - FAX: 763-355-5718

(OFFICE ONLY) **NAME OF SCHOOL THERAPIST** _____

7070 BROOKLYN BLVD, BROOKLYN CENTER, MN 55429