VEEMAH

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Mental Health Therapy Referral Form

Thank you for your referral to organization. We will contact the client within 24 hours of receiving your referral to schedule an appointment. We asked that you kindly inform the client of the nature and reason for the referral.

INFORMATION OF PERSON MAKING REFERRAL

Name: ____ Date: ________________

Phone number: ______________________________ Fax: _______________________

Email: ____

Referral Source (Name of Agency/Organization): ____

Address: ____

CLIENT'S INFORMATION

Name: ____ Date of Birth: ________________

Gender: ______________ Ethnicity: _______________

Funding source: Medical Assistance ☐ UCARE ☐ Blue Plus ☐ Blue Cross Commercial ☐

Health Partners Commercial ☐ Preferred One ☐ Medica ☐ Hennepin Health ☐

Health Partners PMAP

Address: ____

Independent Living? Yes ☐ No ☐ If no, residing with whom? ___________________________

Phone number: _____________________________ Alternate Phone number: _________________

Emergency contact name: _____________________________ Phone Number: ___________________

Name of legal Guardian: _________________________ Phone number: __________________________

Presenting Concerns: ____

Previous Diagnosis if known: ____

Service Referred to:

Individual Therapy ☐
Family Therapy ☐
Couples Therapy ☐

For office use only:
The client was contacted, and appointment scheduled Yes ☐ No ☐ Client did not respond ☐
Name of person completing referral: ____________________________________