Intake/Referral Form

✹✹ VEEMAH

DATE OF INTAKE/REFERRAL & TYPE OF SERVICES

_____/_____/ 2025 | ☐ **Clinc Therapy** | ☐ **CIBHS** | ☐ **Psychological Assessment** *(Provider Referral Required) | ☐ **Immigration Waiver** | ☐ **Diagnostic Assessment**

BASIC INFORMATION

Client Name:_____

If Minor, Name of Parent/Guardian _____

Date Of Birth:_____

☐ Minor
☐ Adult

Address:

Phone:

Race/Nationality: ←----------------------→ We ask to ensure we provide the best care & support based on the clients lived experiences and cultural identity.

Email:

Emergency Contact

CLIENT BACKGROUND

Describe the main reasons you are seeking our services or referring client. Include specific needs, concerns, or goals.

_____

If you or the client referred have any past or current mental health diagnoses from a medical provider, please list them.

_____

Do you/client referred need an interpreter? ☐ No   ☐ Yes + Primary Language _____

REFERRAL INFO/PREFERENCES

Are you the client/client guardian **or** are you referring the client?

☐ I am Client/Guardian

☐ I am Referring Client

If you are referring client please provide your details here:

Name:_____ Relationship: _____

Agency:_____Phone:_____

Fax:_____Email:_____

Feel free to share any additional notes, such as your preference for virtual or in-person appointments or other info.

_____

_____

FUNDING SOURCE

Are you/client using insurance for your service(s) or paying full rate? ☐ Insurance   ☐ Full Clinic Rate

*IF DIFFERENT FROM CLIENT
Policy Holder Full Name & DOB: _____Insurance Name:_____

ID #_____Group #_____ PMI # (IA)_____

Our policy is to verify your coverage before your first appointment to ensure insurance covers the services and avoid unexpected costs.

SUBMITTING INTAKE/REFERRAL

Once completed, please email the form to info@veemahconsulting.com or fax it to 763-355-5718. Alternatively, call us at 763-202-4767 between 9:00 AM and 4:30 PM, Monday through Friday, to provide the information by phone. We will contact you within 3 business days. *Note that for psych testing, a referral from a provider or community support is required, and can be faxed or emailed as well. For school based therapy please contact your childs school social worker to start the process.