Intake & Referral Form

(763) 202-4767 WWW.VEEMAH.COM
VEEMAH
7070 Brooklyn Blvd, Brooklyn Center, MN 55429

TYPE OF SERVICE(S) **Intake/Referral Date:** _____

☐ **Clinc Therapy** ☐ **School Therapy** ☐ **Psychological Assessment** (Referral is required) ☐ **Immigration Waiver** ☐ **Diagnostic Assessment** ☐ **Wellness Groups**

BASIC INFORMATION

Client Name:_____ Sex: _____ ☐ Minor ☐ Adult

Parent/Guardian (if applicable):_____ Date Of Birth:_____

Address: _____ Phone:_____

Email:_____ Race/Nationality:_____

Emergency Contact: _____

Does the client or family need an interpreter? ☐ No ☐ Yes + Primary Language _____

CLIENT BACKGROUND

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

_____

_____

Has the client been diagnosed with any mental health conditions by a qualified provider? **If yes, please list them here:**

_____

_____

REFERENT INFORMATION

Referring providers should include a signed ROI if care coordination or records are needed.

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

☐ I'm the client/guardian

☐ I'm referring client

If you are referring a client, please provide your contact details below:

Name:_____ Relationship: _____

Agency/Clinic:_____ Phone:_____

Fax:_____ Email:_____

You may include any additional details that would help us best support client:

_____

_____

FUNDING SOURCE

VEEMAH Policy: Insurance will be verified prior to scheduling. Verification does not guarantee coverage or final out-of-pocket costs.

Is client using insurance for your service(s) or paying full rate? ☐ Insurance ☐ Clinic Rate

Policy Holder Name & DOB: _____ Insurance Name:_____

*IF DIFFERENT FROM CLIENT

ID #_____ Group #_____ PMI # _____

Intake/Referral Submission Instructions: Submit referrals to referral@veemahconsulting.com, fax (763) 355-5718, or deliver them to our office. Our office will make up to three attempts to contact the client for scheduling. Psychological assessment & testing referrals require a referral from a licensed provider or professional community partner. Clients and families may call (763) 202-4767 to confirm receipt of referral or schedule if they have not received follow-up within two weeks of submission.

Last Updated: July 2026