**Referral Form**

700 Cedar Street Alexandria, MN 56308 • P-320-313-1155 • F-855-344-1728 • info@anchorswellness.org

**Date of Referral: \_\_\_ / \_\_\_ / \_\_\_\_\_\_**

**Client Information**

* **Full Name:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_
* **Date of Birth:** \_\_\_ / \_\_\_ / \_\_\_\_\_\_
* **Gender:** ☐ Male ☐ Female ☐ Nonbinary ☐ Other: \_\_\_\_\_\_\_\_\_\_
* **Phone Number:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_
* **Email Address:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_
* **Address:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_
* **Preferred Language:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_
* **Insurance Provider:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Policy #: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_
* **Emergency Contact Name/Phone:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Referral Source (Person/Agency Making Referral)**

* **Name:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_
* **Title/Role:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_
* **Agency/Organization:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_
* **Phone Number:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_
* **Email Address:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_
* **Relationship to Client:** ☐ PCP ☐ School ☐ Social Worker ☐ Therapist ☐ Other: \_\_\_\_\_\_\_\_\_\_\_\_

**Reason for Referral (check all that apply):**

☐ Diagnostic Evaluation  
☐ Individual Therapy  
☐ Family Therapy  
☐ Medication Evaluation/Management  
☐ Case Management  
☐ Substance Use Counseling  
☐ Crisis Services  
☐ Psychiatric Services  
☐ School-Based Services  
☐ Other: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Presenting Concerns (brief summary):**

**Current Services/Providers (if any):**

* **Provider Name(s):** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_
* **Type of Service(s):** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_
* **Start Date:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_
* **Frequency:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Risk/Safety Concerns (if any):**

☐ Suicidal Ideation  
☐ Self-Harm  
☐ Homicidal Ideation  
☐ Substance Abuse  
☐ History of Trauma/Abuse  
☐ Recent Hospitalization  
☐ Other: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Please describe briefly:

**Additional Notes or Special Considerations (language needs, cultural considerations, etc.):**

**Supporting Documentation Attached:**

☐ Release of Information (ROI)  
☐ Assessment/Evaluation  
☐ School Reports  
☐ Medical Records  
☐ Other: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Signature of Referring Party:**

**Signature:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  
**Date:** \_\_\_ / \_\_\_ / \_\_\_\_\_\_