**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:** \_\_\_ / \_\_\_ / \_\_\_\_\_\_