VIBRANT LIFE
THERAPY
Mindful · Inclusive · Holistic

REFERRAL FORM

Client Information

Full Name
Date of Birth
Preferred Pronouns
Phone
Email
Address

Insurance Information

Insurance Provider
Member ID #
Group #
Policy Holder Name
Policy Holder DOB

Preferred Location for Services

- ☐ Maplewood (In-Person)
- ☐ Minneapolis (In-Person)
- ☐ Virtual (Telehealth - Minnesota only)

Client Identity & Clinician Preferences

We believe the therapeutic relationship matters deeply. Please share anything that would help us create an affirming and supportive match.

Presenting Concerns / Reason for Referral

Anything Else Important for Us to Know

Include scheduling needs, accessibility considerations, past therapy experiences, or other helpful context.

Referral Source

Name/Organization
Relationship to Client
Contact Information

Preferred Next Steps

- ☐ Client will reach out directly
- ☐ Please contact client to schedule
- ☐ Unsure / Open to coordination

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