The Healing Project of MN, LLC

1400 Van Buren Street Suite 200
Minneapolis, MN 55413
Intake: 612-778-2754 | intake@thehealingprojectmn.org

Referral Form

Thank you for referring one of your clients to The Healing Project of MN LLC. We appreciate your partnership and look forward to collaborating with you. Please note: it is okay not to answer every question. If anything is left blank, we will contact the client to obtain additional information.

Client Information

Name				Phone
	First	*Middle*	*Last*	
Address:				Email:
	Street Address		*Apt/Unit #*	
	City	*State*	*Zip Code*	County of Residence

County of Financial Responsibility

Client's preferred method of communication:

Phone Call	Yes ☐	No ☐
Text Message	Yes ☐	No ☐
Email	Yes ☐	No ☐

Client Demographics

Sex: Gender:

Ethnicity: _____

Pronouns: Primary Language:

Does the client need an interpreter? If so, what language?

Language:

Insurance Information

Primary Insurance Company:

ID Number:

Group Number:

Secondary Insurance Company:

ID Number:

Group Number:

Referring Provider Information

Name: Agency:

Phone: Email:

Is the client aware of this referral? Yes ☐ No ☐

Please include a release of information if you have obtained one from the client in your email or fax. If you do not have a release of information on file, we will ask the client if they want to sign one for your agency when we make contact. If the client decides to sign a release of information, we will keep you updated on the referral process.

Referral Reason

What program(s)/service(s) are you referring the client for?

Please add a short description of the current challenges:

Please provide any PROTECTIVE factors that would benefit us to be aware of.

Please provide any RISK factors that would benefit us to be aware of.

Please include any additional information you would like us to know.

Please send referral and release of information to:
The Healing Project of MN
FAX: 612-520-5622 OR
Email: intake@thehealingprojectmn.org
Please contact us with questions!