REFERRAL FORM

601 Franklin Street Winona MN 55987

Please check the services you are requesting

☐**Children's Therapeutic Services & Supports:**

☐Bridges Day Treatment (Preschool-Kindergarten) ☐Adolescent Day Treatment (12-18yrs)

☐Individual Skills

☐**Outpatient Therapy**

☐Individual ☐Family ☐Couples ☐EMDR ☐Psych Testing

Client Number: _____

Referral Date: _____

<u>Client Demographics</u>: (Please fill out all known information)

_____/____/_____(_____) _____

Identified Client Name DOB Age Location of Client (Address)

_____ _____

Client Phone Client Email

_____ _____

Parent/Legal Guardian Name Phone Parent/Legal Guardian Name Phone

_____ _____

Email Email

_____ _____

Address City/State/Zip Address City/State/Zip

_____ _____

School Contact/ Case Manager Email

_____ _____

School Name City/State/Zip Telephone Number Fax

Grade: _____ Special Education Services: ☐Yes ☐No Ethnicity_____

Referral Information: ☐Court Ordered ☐Voluntary

Referral Source: _____

Referral Source Address: _____

Street City State/Zip

Referral Source Contact: _____

Email Phone Number Fax

Legal:
Curfew: _____ PBT/US Requirements: _____
Pending Legal Action: _____
County of Jurisdiction: _____
Probation Expiration Date: _____

Funding: ***Please attach copies of insurance or MA card*
Funding Source: ☐Commercial Insurance ☐Medicaid ☐None (self-pay)
☐Other (please describe): _____
Health Insurance: _____ Group Number_____
MN Policy Number: _____ ID Number: _____
Social Security Number: _____
Reason for Referral: _____
_____
_____
Significant Events in History: (Divorce, loss of a loved one, traumatic events): _____
_____
_____
Long Term Goals (family intact, transition for returns, other): _____
_____
Current Agencies involved: _____
_____
Past/ Present Interventions:_____
_____
Mental Health Provider or M.D.: _____

Past Diagnostic Assessment Completed ☐ Yes ☐No If Yes, date of most recent DA:_____
Agency with DA:_____
Diagnosis;_____
_____
Types of Therapy: ☐Individual ☐Family ☐Couples ☐EMDR ☐Psych Testing
Type of Therapy Notes_____
Therapist Preference: _____
Notes: _____
_____
_____
_____
_____

Please send referrals to:
Jamaica Dismukes- Intake Specialist
jdismukes@fccnetwork.org
Phone: *(507) 453-9563*
Fax: *(507)453-9562*
Address: *601 Franklin Street Winona MN 55987*