871 Jefferson Avenue, Saint Paul, Minnesota 55102
651-252-1175
vvalero@thehealingplc.org

REFERRAL FORM

DATE: _____

REFERRAL SOURCE

AGENCY: _____ COUNTY: _____

NAME: _____ PHONE _____

EMAIL ADDRESS_____

CLIENT'S NAME _____ DOB: _____

GENDER: _____ AGE ____ ETHNICITY _____

CURRENTLY ON PROBATION? ☐ YES ☐ NO

ADDRESS: _____

PHONE: _____ EMAIL: _____

EMERGENCY CONTACT (NAME AND NUMBER): _____

BEST WAY TO REACH CLIENT: _____

REASON(S) FOR REFERRAL (CHECK ALL THAT APPLY) ☐ INDIVIDUAL THERAPY ☐ GROUP THERAPY
HEALTHY SEXUALITY EDUCATION OTHER: _____

DOCUMENTATION INCLUDED: ☐ PSYCHOSEXUA ☐ COMPLAINT ☐ SENTENCING ORDER ☐ ARREST REPORT ☐ ROI

OTHER _____

BILLING INFORMATION
primary insurance: _____
ID # _____ GROUP # _____ MEDICAID # _____

NAME OF INSURED _____ RELATIONSHIP TO INSURED _____

UNINSURED: ☐ **YES** ☐ **NO** **IF NO, HOW WILL THERAPY SERVICES BE PAID?** _____