Reach for Resources

COUNSELING REFERRAL FORM

Return completed form to counseling@reachforresources.org or (fax) 952-229-4468

Date of Referral: _____ Referred By/Relationship: _____

Agency & Address: _____

Phone: _____ Fax: _____ Email: _____

CLIENT INFORMATION

Name: _____ Preferred Name: _____ DOB: _____ SSN: _____

Address: _____ City/State/Zip: _____

Phone: _____ Gender: ☐ Male ☐ Female ☐ Transgender ☐ Non-binary Preferred Pronouns: ☐ she/her ☐ he/his ☐ they/them

Race/Ethnicity: ☐ White/ Caucasian ☐ Black/ African American ☐ Asian ☐ Latino/a ☐ American Indian/ Alaska Native ☐ Pacific Islander/ Native Hawaiian

Is the client his/her/their own guardian? ☐ Yes ☐ No Mobility Needs: _____

GUARDIAN INFORMATION

Guardian Name: _____ Phone: _____ Email: _____

Relationship to Client: _____ Address: _____

REFERRAL INFORMATION

Is the client aware of this referral? ☐ Yes ☐ No Referral for: ☐ Individual Therapy ☐ CBT Skills Group for ID/DD ☐ CBT Group for Anxiety & Depression

Reason for referral/Areas to address: _____

Name of contact scheduling the client's appts: _____ Phone: _____

INSURANCE INFORMATION

Primary Insurance Provider: _____ Primary Insurance Number: _____

Secondary Insurance Provider: _____ Secondary Insurance Number: _____

MA#: _____ Are you on Medicare? ☐ Yes ☐ No Medicare Number: _____

PLEASE INCLUDE COPIES OF ALL INSURANCE CARDS ALONG WITH REFERRAL IF POSSIBLE.