Children's Therapeutic Services and Supports (CTSS) Referral

Please fax completed forms to 651-342-8020.

Direct Dial: 952-564-6337

Today's Date: _____ **Urgent:** Yes / No Reason: _____

Client's Name: _____ Age: _____ Date of Birth: ___/___/_____ Gender: M / F

Race: _____ Ethnicity: _____ Tribe Member: Yes / No If so, Tribe Name: _____

Legal Guardian 1: _____

Relationship: (_)Parent (_)Foster Parent (_)Other_____

Address: _____

_____

Phone Number: _____

(_)Home (_)Cell (_)Work (_)Other_____

OK to Leave Voicemail? Yes / No

Legal Guardian 2: _____

Relationship: (_)Parent (_)Foster Parent (_)Other_____

Address: _____

_____

Phone Number: _____

(_)Home (_)Cell (_)Work (_)Other_____

OK to Leave Voicemail? Yes / No

Availability: Please select all that apply. (_)Morning (_)Afternoon (_)Evening (_)Saturday (_)Other_____

Referred by: _____ Phone Number: _____

(_)Release of Information Attached

Diagnosis (if known):_____

_____

Other Mental Health Providers Involved? Yes / No If Yes, please attach current diagnostic assessment.

County Involved? Yes / No If Yes, please attach Release of Information.

Primary

Insurance Company: _____

(_)MA (_)PMAP (_)Commercial

Insurance ID#: _____

Group #: _____

Subscriber: _____

Subscriber DOB: _____

Secondary

Insurance Company: _____

(_)MA (_)PMAP (_)Commercial

Insurance ID#: _____

Group #: _____

Subscriber: _____

Subscriber DOB: _____