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

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

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: ________________________________