LifeDevelopment RESOURCES, PA

( ) CTSS (in home)

Referral Form

Please fax to: 651-342-8020

Questions: 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 OK to Leave Voicemail? Y / N

Email: _____

Legal Guardian 2: _____

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

Address: _____

_____

Phone Number: _____

(_)Home (_)Cell (_)Work OK to Leave Voicemail? Y / N

Email: _____

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

**If referred by another provider, please fax release of information (ROI).*

Referred by*: _____ Phone Number: _____

( )County ( )School ( )Other_____ Email: _____

Diagnosis (if known): _____

_____

Other Mental Health Providers Involved? Yes / No If Yes, please fax current Diagnostic Assessment.

Primary

Insurance Company: _____

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

Insurance ID#: _____

Group #: _____

Subscriber: _____

Subscriber DOB: _____

Secondary

Insurance Company: _____

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

Insurance ID#: _____

Group #: _____

Subscriber: _____

Subscriber DOB: _____