Referral for Services from Other Providers Date:_____

Client Information:

Client Name: _____ Client DOB & Gender: _____

Parents/Guardian Name(s): _____

Is this the person legally responsible for the above-named client? ☐ Yes ☐ No

Address: _____

City: _____ State: _____ Zip Code: _____

Home Phone: _____ Cell Phone: _____

Primary Insurance Carrier: _____ Policy #: _____

Secondary Insurance Carrier: _____ Policy #: _____

Current Diagnosis (if any): _____

Is this diagnosis: ☐ Medical ☐ Educational

Referring Provider Information:

Name: _____ Phone #: _____

Agency: _____ Email: _____

Services referring to (check all that apply):

☐Day Treatment (choose option below):

☐ ASD 2-6 years ☐ ASD 6-12 years ☐ SED/ED 3.5-6 years

☐ Mental Health (choose options as applicable):

☐ general ☐ ABC ☐CPP ☐ ITFC ☐ PCIT ☐ TF-CBT ☐Skills

☐Early Childhood Home visiting (0-4 years old) ☐Children's Mental Health Case Management

☐Multi-Disciplinary Assessment (Psychological Eval, OT Eval & ST Eval) ☐Psychological Testing

☐Occupational Therapy ☐Physical Therapy ☐Speech Therapy ☐Feeding Therapy

☐Therapeutic Recreation

☐ Destination Anywhere ☐ Adventure

☐Waivered Services

☐ Hourly Respite ☐ Personal Support ☐ In-Home Family Support

Concerns/Needs/Presenting Issues:

Relevant Family Information/History/Custody Status:

Does the child receive any other services? ☐ Yes ☐ No If Yes, please list: _____

Are parents/guardian aware their child is being referred for services? ☐ Yes ☐ No (Please include signed release of information)

_____

Referring Provider Signature

_____

Parent/Guardian Signature

With questions, please call The Central Office of Resources & Enrollment (CORE) at **651-317-4650**). Fax completed form to **866-338-1322** 7; attn: Navigator

Revised 6.4.19