Please complete the following and send this form, and any additional information to: ashley.kvistberg@stepsforchange.us or fax to 612-465-2861. For additional questions please contact Ashley Kvistberg at 612-393-2259

REFERRAL FORM

Today's Date:

How did you hear about SFC? ☐ **Internet Search** ☐ **Referral** ☐ **Social Media** ☐ **Insurance Company/Provider** ☐ **Legal Representation** ☐**Other**_____

Client Information

Name: Date of Birth: Age:

Address: Primary Language:

City: Sex:

State:

Zip:

Phone:

Referring Person/Agency (if applicable):

Name:

Relation:

Phone:

Reason For Referral:

_____

_____

_____

Services requested:

☐ Individual Therapy ☐ Assessment/Evaluation

☐ Family Therapy ☐ Other

Best day of the week for your appointment:

☐ Monday ☐ Tuesday ☐ Wednesday ☐ Thursday ☐ Friday

Best time of day for your appointment:

☐ Early Morning ☐ Afternoon

☐ Mid-Morning ☐ Late Afternoon

Have you or your child been seen by another therapist?

☐ Yes ☐ NO

If yes, who: _____

Can any of the following be provided?

☐ Court Order(s) (if applicable) ☐ Court report(s) ☐ Police report(s) ☐ CPS Records

☐ Rule 20 ☐ Adaptive Testing ☐ Child Protection Reports ☐ Prior Treatment Records

☐Individualized Education Plan(s) ☐ Mental Health Records (e.g., prior placements, psychiatric)

Health Insurance Carrier (can attach a copy of insurance card instead)

☐ Medical Assistance (MA) MA: MA #:
☐ Blue Cross Blue Shield ☐ Preferred One
☐ Other ☐ Unknown ☐ No Insurance (paying out of pocket)

Policy #: **Group# (if applicable):** **Policy Holder:**

Any additional comments: