ACUMEN
COUNSELING SERVICES, LLC

Mental Health Services Referral Form

CLIENT INFORMATION (COMPLETE AS AVAILABLE)

NAME _____ DATE FO BIRTH: _____

ADDRESS _____

HOME PHONE (_____) _____ WORK HOME (_____) _____

CELL PHONE (_____) _____ _____: (_____) _____

PARENT/GUARDIAN/OTHER _____

☐ ***BIOLOGICAL PARENT*** ☐ ***LEGAL GUARDIAN (MUST PROVIDE LEGAL DOCUMENTS FOR VERIFICATION)***

HOME PHONE (_____) _____ WORK HOME (_____) _____

EMERGENCY CONTACT _____

HOME PHONE (_____) _____ WORK HOME (_____) _____

ATTORNEY (IF APPLICABLE) _____

ADDRESS _____ OFFICE PHONE (_____) _____

REFERRAL SOURCE (AGENCY/PERSON) _____

CONTACT _____ WORK HOME (_____) _____

FAX NUMBER (_____) _____ EMAIL ADDRESS _____

REASON(S) FOR REFERRAL (CHECK ALL THAT APPLY)

☐ MENTAL HEALTH ASSESSMENT ☐ INDIVIDUAL THERAPY ☐ DBT THERAPY ☐ FAMILY THERAPY

BRIEF DESCRIPTION OF PROBLEM (ATTACH SEPARATE SHEET IF NECESSARY. PLEASE FORWARD MEDICAL & BEHAVIORAL INFORMATION, COURT REPORTS, SOCIAL SUMMARIES, PREVIOUS EVALUATIONS, ETC.)

_____

_____

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_____

_____

BILLING INFORMATION

PRIMARY INSURANCE COMPANY _____

POLICY # _____ GROUP # _____ PHONE (_____) _____

DOES CLIENT HAVE ANY OTHER FORM OF INSURANCE? ☐ **YES** ☐ **NO** ☐ **PENDING:** _____

902 E. 2nd Street, Suite 326, Winona, MN 55987 P.O. Box 30025 Winona, MN 55987
T: 855-855-6776 W: www.AcumenCS.com F: 855-211-8645