



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 763.568.7223. Fax completed form to 855-437-8697; attn: Navigator