



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