



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