

THERAPEUTIC SERVICES AGENCY, INC.

220 Railroad St. S.E. • Pine City, MN 55063 • (320) 629-7600 • Depot Fax (320) 629-7900 • www.hoperealized.com

Family Based and Outpatient Services Referral Information

Routed to: KEA KAB
 DJB RMM ME

Date of Referral: _____ County: _____
Case #: _____

Received By: _____ Assigned To: _____
Office Use Only

Client and Family Information

Identified Client	DOB	Age	Sex	Relation-ship	MA #	SS#	Race (Use Key)	Resides With
Name-								
TSA Client #								
Other Family Members	DOB	Age	Sex	Relation-ship	MA #	SS#	Race (Use Key)	Resides With
Name-								
TSA Client #								
Name-								
TSA Client #								
Name-								
TSA Client #								
Name-								
TSA Client #								

Race Key: White = **W** Black = **B** Am. Indian = **AI** Asian = **A** Nat. Hawaiian & Other Pacific Islander = **P** Hispanic = **H** Other = **O** Not Known = **NK**

Family Address: _____

Legal Guardian of Identified (Minor) Client: _____

City: _____ Zip: _____

Availability for Services: (check all that apply)

OK To Call

M Tu W Th F Sa Su

Family Phone: _____

Mornings Afternoons Evenings

Work Phone: _____

Cell Phone: _____

Previous TSA Client: Yes No

Referral Information

Referring Worker: _____

If self referral, how did they hear about TSA: _____

Agency: _____

Phone #: _____

Services To Be Provided –For descriptions of services, please refer to corresponding webpage at www.hoperealized.com or call 320-629-7600

- | | |
|---|--|
| <input type="checkbox"/> Family Counseling | <input type="checkbox"/> Individual Counseling |
| <input type="checkbox"/> Family Skills | <input type="checkbox"/> Individual Skills |
| <input type="checkbox"/> In- School Counseling | <input type="checkbox"/> Supervised Visitation |
| <input type="checkbox"/> Parenting Assessment | <input type="checkbox"/> Outpatient Services |
| <input type="checkbox"/> Attachment Assessment | <input type="checkbox"/> Diagnostic Assessment |
| <input type="checkbox"/> Psychological Evaluation | |

Previous or Existing Diagnosis Information:

Diagnostic Assessment completed Yes No

DA is CTSS compliant Yes (if yes, services may begin)

Date of DA _____

Who completed/will be completing DA?

Additional Information

Reason for Referral/Presenting Problem:

Brief History as it Relates to Referral:
(Include past placement, treatment, court involvement, etc.)

School Status:

Strengths:

Referring Worker Expectations:

Other Current Service Providers:

Linguistic Considerations or Other Special Needs:

County Release of Information Secured: ___yes ___ no

Funding Sources		
___ Medical Assistance	___ Insurance ___ PMAP	___ County Purchase of Service
___ CTSS ___ DA ___ Outpatient ___ Children's Mental Health ___ Adult Mental Health ___ Other _____ MA#: _____	___ CTSS ___ DA ___ Outpatient Insurance Co: _____ ID#: _____ Group #: _____ Insured Person: _____ DOB of Insured Person: _____ SS# of Insured Person: _____	Contract Dates: _____ _____ Hours Authorized: _____ ___ Self Pay