Routed to:
__Karen __Becky __Deb
__Melissa __Karin __Bruce
__Linda _____

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

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

Office Use Only:
Received By: _____
Assigned To: _____

Client and Family Information

Family Name: _____

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: _____

_____

City: _____ Zip: _____

OK To Call

Family Phone: _____ _____

Work Phone: _____ _____

Cell Phone: _____ _____

Legal Guardian of Identified (Minor) Client:

_____

Availability for Services: (check all that apply)

__M __Tu __W __Th __F __Sa __Su

___Mornings ___Afternoons ___Evenings

Previous TSA Client: ____Yes ____ No

Referral Information

Referring Worker: _____

Agency: _____

Phone #: _____

If self referral, how did they hear about TSA:

_____

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

____ Family Counseling
____ Family Skills
____In- School Counseling
____Parenting Assessment
____Attachment Assessment
____ Psychological Evaluation
____ Individual Counseling
____Individual Skills
____Supervised Visitation
____Outpatient Services
____Diagnostic Assessment

Previous or Existing Diagnosis Information:

Diagnostic Assessment completed ___Yes ___ No
DA is CTSS compliant ___Yes (if yes, services may begin) NA____
Date of DA _____
Who completed/will be completing DA?_____
How can TSA get a copy of 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:

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 Deductible _____ Co-Pay _____ Insurance Co: _____ ID#: _____ Group #: _____ Insured Person: _____ DOB of Insured Person: _____ SS# of Insured Person:_____	Contract Dates: _____ _____ Hours Authorized: _____ ___ **Self Pay**