THERAPEUTIC SERVICES AGENCY, INC.

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

School Based Mental Health Services

Referral Information

Date of Referral: _____

Client and Family Information

Family Name: _____

Identified Client	DOB	Age	Sex	Grade	SS#	Race (Use Key)	Resides With
Name-							

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

Other Family Members:

Name	Relationship	Name	Relationship
_____		_____	
_____		_____	
_____		_____	

Family Address: _____

_____

City: _____ Zip: _____

OK To Call

Family Phone: _____ _____

Work Phone: _____ _____

Cell Phone: _____ _____

Legal Guardian of Identified (Minor) Client:

_____

Previous TSA Client: ____Yes ____ No

Referral Information

Referring Person: _____

School: _____

Phone #: _____

E-Mail _____

Release of Information secured ____Yes

Written _____ Verbal____

If written, please fax along with referral form

Reason for Referral/Presenting Problem:

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

School Status:

Strengths:

Other Current Service Providers:

Linguistic Considerations or Other Special Needs:

Other information:

Funding Sources			
____**Medical Assistance**	____**Insurance** ___**PMAP**	____**County Contract**	____**Self Pay**
MA#: _____ _____	Insurance Co:_____ ID#_____ Group#_____ Insured Person: _____ DOB of Insured Person: _____ SS# of Insured Person:_____ Insured Person: _____	Contract Dates _____ _____ Hours Authorized _____	

Office Use Only

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?_____

Received by: _____

Assigned to: _____