the Guidance Group COUNSELING

Duluth t 218.576.5757 f 844.576.5767
Virginia t 218.288.6001 f 833.248.8484
Ashland t 715.979.5239 f 833.239.2929

REFERRAL INTAKE FORM

Service Requested ☐**Dx Assmt** ☐**CD Assmt** ☐**Individual** ☐**Couple** ☐**Family** ☐**EAP** ☐**Med Eval/Mgmt** ☐**Group**_____

Location ☐**DLH** ☐**VIR** ☐**ASH** ☐**Telehealth** ☐**In-Home** ☐**School** | **Therapist Requested:** _____

Client Information

Client Name: F]_____ MI]_____ L]_____ Age: _____ DOB: _____ / _____ / _____

Legal Gender Marker: ___ Gender Identity: _____ Race/ethnicity: _____ Employer/School (grade): _____

Address: _____ City: _____ Zip: _____

Home #: _____ VM ok □ | Cell #: _____VM ok □ | Work #: _____ VM ok □

Email for portal: _____ Reminders: text □ phone call □ email □

Primary Caretaker (if minor): _____ Relationship: _____

Emergency Contact _____ Relationship _____ Contact # _____

Parent / Legal Guardian Information (if minor)

Please list Parents' names, DOB, addresses and phone numbers, if different from above:

Parent 1 or Mother: Parent 2 or Father:

_____ _____

_____ _____

_____ _____

Custody arrangements if applicable: _____ ☐ advised that copy of div decree/custody order is required prior to onset of services if applicable.

Referral Information

Referral Source: _____ Agency/Division: _____

Phone: _____ FAX: _____

Current Social Services/Probation/Psychological Services involvement: ____ Yes ____ No

Explain: _____

Current DX: _____ Medications: _____

Reasons for Referral: _____

_____

Financially Responsible Party Name: _____ DOB _____ Phone _____

Insurance ***In-network:*** ☐Aetna ☐BCBS ☐CIGNA ☐ForwardHealth ☐HealthPartners ☐Medica/UHC/Optum ☐PreferredOne ☐UCare ☐Medicare B ***Not in-network:*** ☐GHC of Eau Claire ☐WEA ☐Security Health

Type: ☐Commercial (thru employer) ☐Health Exchange or Individual (self purchased) ☐Govt (ie. MA, MNCare, BadgerCare) ☐Supplemental

☐Medicare (number if applicable):_____ ☐EAP: _____ # of sess: _____

Employer _____ MHCP# (8-digit) _____ County responsible _____

Policy holder: _____ Member ID# _____ Group # _____

Policy holder DOB: _____ / _____ / _____ Policy # if listed:_____ Customer Svc # _____

Policy holder Phone: _____ Client's Member ID, if different from Policy Holder's _____

Other Payment Arrangements (if applicable): _____