THERAPEUTIC SERVICES AGENCY, INC.

220 Railroad St. S.E. ▪ Pine City, MN 55063 ▪ (320) 629-7600 ▪
Depot Fax (651) 925-0071 ▪ www.hoperealized.com

Routed to:
__Tami __Karin ___ Mary
___Brandye ___Kiosk ____ WA
___Christine ___Bruce
___ Mitch
Printed to __ Hillside
__Hilltop __CR __ StPaul
___Cambridge

FBS and Outpatient Services Referral Information

Date of Referral: __________ County: ______________ Received By: ____________________ Stairs ok? Y N

Assigned To: ___________________ Location _____________

Client and Family Information

Identified Client	DOB	Age	Sex	Relationship	Race (Use Key)	Legal Custody/ Lives with
Name- TSA Client #					H NH	

Other Family Members	Age	Sex	Relationship to Client / Other Info
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**

Client Address: _________________________________
____

City: ____________________ Zip: __________________

OK To Leave Messages?

Phone: _______________________ _________ Y / N
Phone: _______________________ _________ Y / N
Phone: _______________________ _________ Y / N

Availability for Services: (check all that apply)
____M ____Tu ____W ____Th ____F ____Sa ____Su
___Mornings ___Afternoons ___Evenings

Appt Reminder: ____Call ____Text ____Email

Email Address ________________________________

Previous TSA Client: ____Yes ____ No

Date______________________

Referral Information

Referring Worker: ______________________________________ Agency: ____

Phone #: ____ Email: ____

How did you hear about TSA?

__ Family/Friend __ Health Professional __ School __ EAP __ Court __ Phonebook
__ County/Social Services __ Internet __ Employer __ Other _____________________________________

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

____ In-home Counseling: (____ Individual ____Family)
____ In-home Skills: (____Individual ____Family)
____In- School Counseling ____Supervised Visitation
____Group (After School) ____Day Treatement
____Parenting Assessment ____Outpatient Services
____Attachment Assessment ____Diagnostic Assessment
____ Psychological Evaluation

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 Seeking Counseling Services/History:

School: ______________________________________ Grade:______ IEP _____ 504 _____

Status:

Counseling: What Changes Do You Want To Happen As A Result of Counseling:
Psyc Eval: What Question do you want answered by Psych Eval:

Other Service Provider's:

County Worker ______________________________ Probation Officer ______________________________

Psychiatrist _________________________________ GAL ____

Primary Care _______________________________ Other ______________________________________

☐ Hearing Impairment ☐ Language Barrier ☐ Learning Disability ☐ Other: ___________________________________

Insurance Information

Insurance/MA ________________________ ID/PMI#: _________________________________ Group #: ___________

Insurance/MA ________________________ ID/PMI#: _________________________________ Group #: ___________

Provider Phone Number (from back of ins. card): _________________________________

Subscriber Name: ____________________________ DOB: ___________ Employer: ____________________________

Subscriber Address: ____

Authorization #: _________________ # of Sessions Allowed ___________ EAP: ______________________________

Copay: __________ Deductible: ___________ Coinsurance: __________ R40/Supervisory Protocol: _______________

Provider Credentials: ________________ Other Limitations: ____

County Contract _____________ to ____________ ______________ Hours County: _________________________

Private Pay Information: ____