# THERAPEUTIC SERVICES AGENCY, INC.

220 Railroad St. S.E. ▪ Pine City, MN 55063 ▪ (320) 629-7600 ▪ Depot Fax (651)925-0071 ▪ 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#: _____<br>_____ | Insurance Co:_____<br>ID#_____<br>Group#_____<br>Insured Person: _____<br>DOB of Insured Person: _____<br>SS# of Insured Person:_____<br>Insured Person: _____ | Contract Dates<br>_____<br>_____<br>Hours Authorized<br>_____ | |

## 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: _____