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

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**

Legal Guardian of Identified (Minor) Client: ____

Family Address: ____________________________

____

City: ______________ Zip: __________________

Previous TSA Client: ____Yes ____ No

Parent Email:_________________________________

Parent Email: _______________________________

		Name
Family Phone:	_____________________	__________
Work Phone:	______________________	__________
Cell Phone:	_______________________	__________

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:

School ____ Grade ________ IEP ______ 504 ______

Other Current Service Providers:

County Worker _____________________________ Probation _________________________________

Psychiatrist _________________________________ GAL ______________________________________

Primary Care ________________________________ CTSS Worker_______________________________

Mental Health Agency ________________________

Other information:

Previous or Existing Diagnosis Information:	**Insurance/MA**
Diagnostic Assessment completed ___Yes ___ No DA is CTSS compliant ___Yes (if yes, services may begin) Date of DA ___________________________________ Who completed DA____________________________ How can TSA get a copy of DA? __________________	ID/PMI# __________________________________ Group # __________________________________ Subscriber Name ___________________________ Subscriber D.O. B. ____________________ Subscriber Employer: ________________________ Subscriber Address: ___________________________ ____ Supervisory Protocol Allowed: _________________