Lighthouse Child & Family Services

Chart #: _____

ARMHS/CSP Referral Form

Client Information

Name of Client: _____ Date of Referral: _____

County: _____ Date of Birth: _____ Sex: _____M_____F_____Other

Address: _____ Phone #: _____

Diagnosis: _____ Alt Phone #: _____

Insurance Company: _____ Date Insurance Began: _____

Primary Client Policy ID#: _____ Group #: _____

Name of Policy Holder (if different from client): _____ Date of Birth: _____

Policy Holder Address: _____

Custodial Care Information (if applicable): _____

Referral Source Information

Name: _____ County: _____ Phone #_____

Address: _____ Fax #: _____

Reason for Referral:

_____

_____

_____

Current services and/or past services provided:

_____

_____

_____

An updated and completed Diagnostic Assessment is needed; please include with this referral from, if possible. We can help you with getting a Diagnostic Assessment if you need help. A signed Release of Information should also accompany the referral.

Please submit the referral form and attachments to:

Lighthouse Child & Family Services
160 3rd Avenue Northwest | Milaca, MN 56353
Office: (320) 983-2335 | Fax: (651) 342-8029
www.lighthousecfs.com

Each of us has a light within. So, let it shine!

_____ _____

Signature of Individual Making the Referral Date