Lighthouse Child & Family Services Referral Form

Chart # _______

Client Information

Name of Client: ____ Preferred Name: ________________________

Date of Birth: _________________ Sex: _____________ Gender: ______________ Race: ___________________

Address: ____

Address is: ____ Client Lives With: ____

Insurance Company: ___________________________________ Date Insurance Began: ___________________

Primary Client Policy ID#: _______________________________ Group #: ________________________________

Policy Holder Name: ____________________________________ Policy Holder Date of Birth: _______________

Policy Holder ID#: ______________________________________ Group #: _______________________________

(Adult Client Only): Phone number: ________________________ Email Address: ___________________________

Custodial Information

Caregiver 1: ______________________________ Relationship: ________________ Date of Birth: _____________________

Address: _______________________________ Phone #: ___________________ Email Address: ___________________________

Legal Custody: __________________________ Physical Custody: _____________________

Caregiver 2: ______________________________ Relationship: ________________ Date of Birth: _____________________

Address: _______________________________ Phone #: ___________________ Email Address: ___________________________

Legal Custody: __________________________ Physical Custody: _____________________

Other Relevant Custody Information (please specify if above caregivers are not biological parents): _________________________

____

____

Referral Source

Referral Source Name, Phone, Agency: ____ Today's Date: _______________

Referring Agency: ____

Reason for Referral: ____

Program/Service:

☐ Diagnostic Assessment

☐ Individual therapy

☐ Family therapy

☐ Couple/Marriage therapy

☐ CSP/CSP Group

☐ ARMHS/ARMHS Group

☐ Adult DBT Program

☐ Adolescent DBT Program

☐ School Linked Mental Health

School/Grade/Teacher:

☐ Intensive Treatment in Foster Care

☐ Children Day Treatment

☐ Preschool Day Treatment

Current Services: ____

Please return this form along with completed Release(s) of Information and Relevant Custody Records to Intake Department

160 3RD AVE NW, MILACA, MN, 56353 | PHONE: 320-983-2335 | FAX: 651-342-8029 | LIGHTHOUSECFS.COM