150 10th St NW, Suite 2, Milaca, MN 56353
P: 320-983-2335 | F: 651-342-8029
www.lighthousecfs.com

CLIENT REFERRAL FORM

Client Information

Client Name: _____ 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: _____
Today's Date: _____ Referring Agency: _____
Reason for Referral: _____

Program/Service(s)

☐ Diagnostic Assessment
☐ Individual therapy
☐ Family therapy
☐ Couple/Marriage therapy
☐ CSP/CSP Group
☐ ARMHS/ARMHS Group
☐ Adult DBT Program
☐ Adolescent DBT Program
☐ School Linked Behavioral Health
☐ Intensive Treatment in Foster Care
☐ Children Day Treatment
☐ Preschool Day Treatment

School/Grade/Teacher: _____

Client's Current Services: _____

Return this form along with completed Release(s) of Information and relevant custody records to the LCFS Intake Department via:
Fax: 651-342-8029 OR LCFS Website → Forms → Upload Form