P.O.R. Emotional Wellness

Helping people build powerful relationships

8421 Wayzata Boulevard Suite 250, Golden Valley MN 55426 • Phone (952)835-6540 • Fax (952)835-6650

PLEASE COMPLETE ALL SECTIONS Date: _____

CLIENT INFORMATION

Client Name: _____ DOB: _____

Gender: ◯M ◯F ◯Gender Non-Conforming Social Security Number: _____

Address: _____
(City) (State) (Zip)

Client Resides with: ☐Parent ☐Foster Parent ☐Grandparent ☐Other: _____

Parent Name: _____ Legal Guardian (if different) _____

Home Phone: ( )_____ Alternative Phone: ( )_____

Ethnicity: _____ Preferred Language: _____

Emergency Contact Name: _____ Phone: ( )_____

School: _____ Phone: ( )_____

REFERRAL SOURCE INFORMATION

Referring Person & Agency: _____

Address: _____
(City) (State) (Zip)

Phone: ( )_____ Fax: ( )_____ Email: _____

Describe presenting issues: _____

_____

_____

PAYMENT INFORMATION

Insurance: _____ Policy Holder: _____

Policy Number: _____ Group Number: _____

PROVIDER PREFERENCES: ☐**No Preference**

Gender: ☐ Male ☐ Female **Culture/Religion**_____

Availability ☐Day Time ☐Evenings

SERVICES REQUESTED

☐ Case Management ☐Diagnostic Assessment ☐ Individual Life Skills ☐ Individual Psychotherapy
☐Family Life Skills ☐Family Psychotherapy ☐ Play/Art Therapy

COLLATERAL CONTACTS:

Therapist/Psychologist: _____ Phone: _____

Psychiatrist: _____ Phone: _____

Other: _____ Phone: _____

Release of Information MUST be attached to this form AND signed by the parent or legal guardian.
If a Diagnostic Assessment has been performed within the last 6 months please submit with Referral.
Please note failure to provide this information will delay referral process.
Please fax completed Referral Forms to (952)835-6650