P.O.R. Emotional Wellness
Power of Relationships
8421 Wayzata Blvd., Ste 250
Golden Valley, MN 55426
Office: (952) 835.6540
Clinical Fax: (651) 925.0089

PLEASE COMPLETE ALL SECTIONS Date: _____

CLIENT INFORMATION

Client Name: _____ DOB: _____

Gender: ☐ M ☐ F ☐ Gender Non-Conforming SSN: _____

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 AND Agency: _____

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

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

Describe presenting issues: _____

_____

_____

PAYMENT INFORMATION

Insurance: _____ Policy Holder: _____

Policy Number: _____ Group Number: _____

PROVIDER PREFERENCES:

☐ **No Preference** **Availability** ☐ Day Time ☐ Evenings

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

SERVICES REQUESTED

☐ Case Management ☐ Diagnostic Assessment ☐ Individual Life Skills ☐ Individual Psychotherapy
☐ Family Life Skills ☐ Family Psychotherapy ☐ Play Therapy ☐ Day Treatment

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 Kristen at (651) 925-0089