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: _____ Pronouns: _____

DOB: _____ SSN: _____ Gender Identity: _____

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

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

Parent Name: _____ Legal Guardian (if different) _____

Home Phone: _____ Alternative Phone: _____

Email: _____

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: _____

SERVICES REQUESTED

☐ Case Management ☐Diagnostic Assessment ☐ Skills Training ☐ Psychotherapy
☐ Art/Play Therapy ☐ Social Skills Group ☐ Autism/CMDE Eval

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