# THERAPEUTIC SERVICES AGENCY, INC.

220 Railroad St. S.E. ▪ Pine City, MN 55063 ▪ (320) 629-7600
Depot Fax (651) 925-0071 ▪ www.hoperealized.com

Routed to:
__Billing
__ Faxed ___ In Person
___Mailed ___Kiosk ____ WA
___Christine ___ Lainie
___SLMH ___DHH

## FBS and Outpatient Services Referral Information

Date of Referral: _____ County: _____ Received By: _____ Stairs ok? Y N

Assigned To: _____ Location _____

## Client and Family Information

| Identified Client | DOB | Age | Sex | Relationship | Race (Use Key) | Legal Custody/ Lives with |
|---|---|---|---|---|---|---|
| Name- <br> TSA Client # | | | | | H NH | |

| Other Family Members | Age | Sex | Relationship to Client / Other Info |
|---|---|---|---|
| Name- <br> TSA Client # | | | |
| Name- <br> TSA Client # | | | |
| Name- <br> TSA Client # | | | |
| Name- <br> TSA Client # | | | |

Race Key: White = **W** Black = **B** Am. Indian = **AI** Asian = **A** Nat. Hawaiian & Other Pacific Islander = **P** Hispanic = **H** Other = **O** Not Known = **NK**

Client Address: _____

_____

City: _____ Zip: _____

OK To Leave Messages?

Phone: _____ _____ Y / N

Phone: _____ _____ Y / N

Phone: _____ _____ Y / N

Availability for Services: (check all that apply)

____M ____Tu ____W ____Th ____F ____Sa ____Su

___Mornings ___Afternoons ___Evenings

Appt Reminder: ____Call ____Text ____Email

Email Address _____

Previous TSA Client: ____Yes ____ No

Date_____

## Referral Information

Referring Worker: _____ Agency: _____

Phone #: _____ Email: _____

**How did you hear about TSA?**

__ Family/Friend __ Health Professional __ School __ EAP __ Court __ Phonebook

__ County/Social Services __ Internet __ Employer __ Other _____

## Services Requested –For descriptions of services, please refer to corresponding webpage at www.hoperealized.com or call 320-629-7600

____ In-home Counseling: ( ____ Individual ____Family)

____ In-home Skills: (____Individual ____Family)

____In- School Counseling ____SLMH

____Group (After School) ____Deaf Hard of Hearing

____Outpatient Services ____ Psychological Eval.

____ DC0-5 ____Diagnostic Assessment

**Previous or Existing Diagnosis Information:**

Diagnostic Assessment completed ___Yes ___ No

DA is CTSS compliant ___Yes (if yes, services may begin) NA____

Date of DA _____

Who completed/will be completing DA?_____

How can TSA get a copy of DA?_____

## Additional Information

Reason For Seeking Counseling Services/History:

**School**: _____ Grade:_____ IEP _____ 504 _____

Status:

**Counseling**: What Changes Do You Want To Happen As A Result of Counseling?
**Psyc Eval:** What Question do you want answered by Psych Eval:

**Other Service Provider's:**

County Worker _____ Probation Officer _____

Psychiatrist _____ GAL _____

Primary Care _____ Other _____

DHH: ___Mild Loss ___Moderate Loss ___Severe Loss ___Profound Loss ___Unilateral Loss

☐ Hearing Impairment ☐ Language Barrier ☐ Learning Disability ☐ Other: _____

## Insurance Information

Insurance/MA _____ ID/PMI#: _____ Group #: _____

Insurance/MA _____ ID/PMI#: _____ Group #: _____

Provider Phone Number (from back of ins. card): _____

Subscriber Name: _____ DOB: _____ Employer: _____

Subscriber Address: _____

Authorization #: _____ # of Sessions Allowed _____ EAP: _____

Copay: _____ Deductible: _____ Coinsurance: _____ R40/Supervisory Protocol: _____

Provider Credentials: _____ Other Limitations: _____

County Contract _____ to _____ _____ Hours County: _____

Private Pay Information: _____