Counseling Services of Southern Minnesota

Professional Referral Form for Psychological Assessment

Referral Source Information:

Name:	Role:
County/Agency/Clinic:	Phone:
Fax:	E-mail:

***Please include a completed Release of Information (ROI) so we can contact you if we have additional questions.**

Patient Information:

Name:	Date of Birth:
Parents/Guardian(s):	Phone:
Address:	
Primary Insurance:	
ID #:	Group #:

Reason for Referral:

Please include presenting problems/current symptoms and why you are seeking a psychological evaluation.

Current Service Providers/Services:

Please include medical, mental health, legal providers, etc. If the patient is receiving special education services, please include the category under which they qualify.

Current Medical and Mental Health Diagnoses:

Thank you for your referral. Please complete this form and fax to: Attn Intake Dept 507-931-8060. Any additional questions can be directed to the intake department at 507-931-8040.