Creative Connections

Referral Form

Please complete all areas and fax to Creative Connections Counseling (320) 407-1120

Date: _____

Reason for Referral: _____

_____

_____

_____

_____

PATIENT IDENTIFCATION

Patient's Name: _____

Address: _____

City: _____ State: _____ Zip: _____

Home Phone #: _____ Birthdate: _____ Sex: Male Female

INSURANCE INFORMATION

Primary Insurance Company: _____ Effective Date: _____

ID Number: _____ Group Number: _____

Secondary Insurance Company: _____ Effective Date: _____

ID Number: _____ Group Number: _____

IF A MINOR Complete the following Information

School: _____ Grade: _____

Guardian's Name: _____ Preferred Phone #: _____

Guardian's Name: _____ Preferred Phone #: _____

Who is the child currently living with? _____

Legal Guardian: _____

Creative Connections

REFERRAL CONTACT

Referring Professional Name: _____

Referring Agency: _____

Phone Number: _____

Email Address: _____

REFERRAL PREFERENCES

Preferred Therapist:

☐ Rachel Trout	☐ Noel Kern	☐Alex Gregory
☐ Stacy Kriese	☐ Rebecca Cluever	☐ Brittany Reinke
☐Heather Anderson	☐ Marie Bourne	☐ No Preference

Preferred Location:

☐ Saint Cloud Office	☐Cold Spring Office	☐ No Preference