12-2004 Version

Cairns Psychological Servicess
16204 Highway 7
Minnetonka, MN. 55345

Program Referral Form

Today's Date: _____
Please Print the Below Information

Client Name: _____ DOB: _____ Age: _____

Address: _____ Case # _____

City: _____State/Zip: _____

Child is living: _____ _____ _____ _____ _____
with parent(s) foster care group home residential treatment other (specify)

_____
(Name of Parent/Foster Parent/Group Home or Treatment Center)

Address (if different from above): _____

City/Zip_____

Phone: (HM)_____ (WK) _____

Child's Mental Health Diagnosis: _____

(Please write on the back if you need more room for your answers to the below questions)

Why are you referring this child to our program?

What are the child's current mental health treatment goals?

What are the child's assets and strengths?

What specific issues would you and/or the child like to address during this program?

Does this child have a history of animal abuse/cruelty? Yes No
If Yes, how recent did an event occur?

Additional information that would be relevant/helpful in providing services for this child:
(Please Print the below information)

_____
Health Care Professional/Referral Name Title/State Credentials

_____
Address

_____
City/State/Zip E-mail Address

Phone: _____ Fax: _____