Village Wellness Center

Intake Line (651) 269-2760

CTSS / EIDBI Referral Form

DATE: _____/_____/_____

Select One:	Type of service(s) requesting ☐ CTSS ☐ EIDBI ☐Diagnostic Assessment ☐ Individual Therapy ☐ Family Therapy ☐ Grp. Therapy

Referral source (Name/Agency/Relationship):	Phone #:

Client Name:	DOB:	SS#:

Parent/ Legal Guardian (s):	Relationship to Client:

Address:	City:	State	Zip:

Home Phone:	Cell Phone:	Work Phone:

Age:	Sex:	School:	Grade:	Ethnicity

Presenting Problem AND Current Family Situation:

Emergency Contact Name:	**Phone Number:**

Insurance (Include member Id, Group# and PMI if possible)

Insurance Name:	**ID#:**

PMI #:	**Group #:**

Is the child receiving therapy? ☐ **Yes** ☐ **No**

If yes please provide the name of the therapist

Name of therapist:	**Phone number:**