Cairns Psychological Servicess 16204 Highway 7 Minnetonka, MN. 55345

Program Referral Form

Today's Date: Please Print the Below Information	 1			
Client Name:			DOB:	Age:
Address:				
City:				
Child is living: with parent(s)	foster care	group home	residential treatment	other (specify)
(Name of	f Parent/Foster I	Parent/Group Hon	ne 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 no	eed more room	for your answers	to the below questions)	
Why are you referring this child to	our program?			
What are the child's current menta	al health treatme	ent goals?		
What are the child's assets and st	rengths?			
What specific issues would you ar	nd/or the child lil	ke to address duri	ng this program?	
Does this child have a history of a If Yes, how recent did an event or		uelty? Yes No		
Additional information that would (Please Print the below informa		ful in providing se	rvices for this child:	
Health Care Professional	Referral Name	Title	e/State Credentials	
Address				
City/State/Zip		E-	mail Address	
Phone:		Fax:		