Collaborative Counseling

Referral Form~ Fax to 763-210-6886

Please fax this form and we will contact the patient to schedule as soon as possible!

Referring Physician/Provider: _____ Phone: _____

Patient Name: _____ DOB: _____

Patient's Phone: _____ Other Contact Info: _____

Insurance: _____

Please check the box or boxes for type of referral:

- ❑ Individual Therapy
- ❑ Couples Therapy
- ❑ Family Therapy
- ❑ Group Therapy
- ❑ Biofeedback
- ❑ Chemical Health Assessment

Please check areas you are suggesting assessment or treatment:

- ❑ General mental health/diagnosis
- ❑ ADHD/ADD
- ❑ Mood and personality
- ❑ Behavioral functioning
- ❑ Chemical Health/Use
- ❑ Other: _____

Reason for referral and other information:

_____

_____

_____

Maple Grove	**Hudson**	**Eau Claire**	**Lakeville**
12918 63rd Ave N Maple Grove, MN 55369	901 Fourth Street Hudson, WI 54016	1740 Brackett Ave Eau Claire, WI 54701	8500 210th St W Lakeville, MN 55044

Phone: 763-210-9966 ❖ **Fax**: 763-210-6886 ❖ **Website**: www.CollaborativeMN.com