ASPIRE HEAL MN

Aspire Counseling & Consulting Services

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(952) 600-4940 · admin@aspirehealmn.com · aspirehealmn.com

CLIENT REFERRAL FORM

Please complete all fields and fax or email to admin@aspirehealmn.com. We respond within 1 business day.

1. CLIENT / PATIENT INFORMATION

Client First Name

Client Last Name

Date of Birth (MM/DD/YYYY)

Gender

Primary Language

Home Address (Street, City, State, ZIP)

Home Phone

Parent / Guardian Name (if minor)

Parent / Guardian Phone

Parent / Guardian Email

2. INSURANCE & FUNDING

Primary Insurance / MA Number

Policy / Member ID

Secondary Insurance (if any)

Policy / Member ID

Authorization Status: ☐ Pre-authorization obtained ☐ Authorization pending ☐ No authorization required

3. DIAGNOSIS & CLINICAL INFORMATION

Primary Diagnosis

ICD-10 Code

Secondary Diagnosis (if any)

ICD-10 Code

Current Medications (list or write "none")

Functional / Communication Level: ☐ Verbal ☐ Minimally verbal ☐ Non-verbal ☐ AAC device user

4. SERVICES REQUESTED

☐ **EIDBI** — Early Intensive Developmental and Behavioral Intervention — Ages 0–21

☐ **ABA** — Applied Behavior Analysis Therapy — Ages 0–21

☐ **OT** — Occupational Therapy — All ages

Reason for Referral / Primary Goals (please describe):

5. REFERRING PROVIDER / CASE MANAGER

Referring Provider / Agency Name

NPI Number (if applicable)

Contact Name (Case Manager)

Title / Role

Phone

Fax

Email

Preferred Contact Method

Best Time to Reach

Diagnostic evaluation / psychological report

School records / IEP

Previous therapy records

Authorization / Prior Auth approval

MA card / insurance card copy

By signing below, I attest that the information provided is accurate and that I have obtained consent from the client/guardian to share this information with Aspire Counseling and Consulting Services.

Referring Provider Signature

Date

Printed Name & Title