

Email:

Hoffmann Counseling Services

St. Peter—New Ulm—Waseca--Mankato

Main Phone # (507)484-2400

SEND FAX ALL REFERRALS TO FAX NUMBER (507)354-2445

Outpatient Referral

Referral Source:		
Name/Title:		Date:
Agency:		Phone:
Address:		
Email:		Fax:

Eligible Participant:					
Legal				Date of Birth:	
Name:					
Preferred				Gender Assigned	Female
Name:				At Birth:	Male
Address:				Pronouns:	
Phone:					
Email:					
Emergency Contact:		Relationship:		Phone Number:	
Guardian 1			Guardian 2	□ NA	
Name:			Name:		
Address:			Address:		

Client portal access	Client portal access
Phone:	Phone:
Other significant person:	
Case Manager:	Phone:
Probation:	Phone:

Email:

Probation:	Phone:
Therapist:	Phone:
Psychiatrist:	Phone:
	Location:

Insurance:				
Insurance Company Na	ame:			
Insurance Company Pr	none:			
Subscriber ID Numbers	:	Group Number:		
Payer ID:				
Subscriber Name:		Subscriber DOB:		
Subscriber Address:				
Subscriber Relationshi	p:			
County Pay:	Yes	County:		
	No			
Medical Assistance:	Yes	MA Number:		
weuld Assistance.		MA Number.		
	No			
Reason for Referral (fi	ll in text box):			
Service Requested (ch				
Diagnostic Assessment		Trauma Focused Services		
Individual Therapy		Family Therapy		
Parenting		CTSS (Skills Training/Rehabilitative Services)		
Play Therapy		ARMHS (Adult Rehabilitative Mental Health Services)		
		Other:		
Teletherapy (please add email address)				
Please attach the following documents as available:				
Releases of Information Current Insurance Card (front & Back)				

How did you hear about Hoffmann Counseling Services?