partners IN EXCELLENCE
Autism Therapy Centers

www.partnersmn.com

Partners Case Management Referral Form

Date of Completion

Person Making Referral: _____ Relationship to Child: _____

Child's Personal Information				
First Name:	Last Name:		Date of Birth:	Gender: ☐ Male ☐ Female ☐ Other:
Home Address:	City:	State:	ZIP:	
Mailing Address (if different):	City:	State:	ZIP:	Pronouns: ☐ He/Him ☐ They/Them ☐ She/Her ☐ Other:
Home Phone:	Cell Phone:	Email:		

Caregiver 1 Is caregiver 1 a legal guardian? ☐ Yes ☐ No			
First Name:	Last Name:	Relationship to Child:	
Is caregiver 1's address the same as child? ☐ Yes ☐ No -if no, please fill out address below			
Home Address:	City:	State:	ZIP:
Home Phone:	Cell Phone:	Email:	

Caregiver 2 Is caregiver 2 a legal guardian? ☐ Yes ☐ No			
First Name:	Last Name:	Relationship to Child:	
Is caregiver 2's address the same as child? ☐ Yes ☐ No			
Home Address:	City:	State:	ZIP:
Home Phone:	Cell Phone:	Email:	

Current Living Situation				
child lives:	☐ home with family	☐ foster care	☐ group home	☐ other: _____
parents are:	☐ birth parents	☐ adoptive parents	☐ other: _____	
parents are:	☐ married	☐ divorced	☐ separated	☐ other: _____

partners IN EXCELLENCE
Autism Therapy Centers

www.partnersmn.com

Child's Race and Ethnicity check all that apply

- ☐ American Indian/Native Alaskan
- ☐ African-Born
- ☐ Asian
- ☐ Black or African- American
- ☐ Pacific Islander
- ☐ White
- ☐ Other (specify): _____
- ☐ Prefer not to answer

Are you Hispanic or Latino?

- ☐ Yes
- ☐ No

Language

What is the primary language spoken at home? ☐ English ☐ Other: _____

Language Interpreter Used/Needed?	If so, what language?	Sign Language Interpreter Used/Needed?
☐ Yes ☐ No		☐ Yes ☐ No

Preferred Method of Contact

☐ Phone Call ☐ Text Message ☐ Email ☐ Other: _____

Child's Primary Care Provider

Name:	Title:		
Clinic Name:	Phone Number:	Fax Number:	
Clinic Street Address:	City:	State:	ZIP:

Diagnostic Information

What's your child's primary diagnosis?

Date of child's first diagnosis?	Licensed Mental Health Professional / Physician who diagnosed child:
Agency Name:	Phone Number:
Date of Last Evaluation:	Fax Number:

What Supports Does Child Currently Have?

- ☐ Social Worker
- ☐ IEP
- ☐ ABA Services
- ☐ Daycare
- ☐ None
- ☐ Therapist
- ☐ After School Program (please list): _____
- ☐ Respite

School Information Enrolled in school? ☐ Yes ☐ No If no, leave section blank.			
School Name:		IEP: ☐ Yes ☐ No	Date of Most Recent IEP:
Current Grade:	Grade Teacher Name:	Special Education Teacher Name (if applicable):	

Medical Assistance (Write NA if child does not have Medical Assistance)
Child's MA Number:
Has the SMRT process been completed? ☐ Yes ☐ No

Primary Commercial Insurance Current coverage? ☐ Yes ☐ No If no, leave section blank.		
Name of Primary Insurance Company:		
Contract #:	Group #:	ID #:
Insurance Policy Holder:	Policy Holder's Date of Birth:	Relationship to Client:
Employed By:	Occupation:	
Business Address:	Business Phone Number:	