LORENZ CLINIC

Lorenz Clinic Professional Referral Form

To	Lorenz Clinic	**From**	
Lorenz Clinic Fax	(952) 361-6013	**Organization Address**	
Lorenz Clinic Phone	(952) 443-4600	**Organization Zip Code**	
Subject	New Referral	**Date**	

CLIENT INFORMATION

Name	
DOB	
Referral Service	
Language Needs	
Parent/guardian name and phone	
Parent/guardian name and phone	

PROFESSIONAL MAKING REFERRAL

Name	
Title	
Phone	
Email	

Clients referred will receive an assessment to determine appropriate services

SERVICES INTERESTED IN

___ Day Treatment
___ In-Home Family Therapy
___ Individual Therapy
___ Psychiatric Medication Management

BEST FORM OF CLIENT CONTACT

___ Direct contact from Lorenz Clinic
___ From professional regarding the referral

NOTES AND ADDITIONAL INFORMATION

Please fax this form and a release of information to (952) 361-6013. For any questions regarding this process, please call (952) 443-4600.