



# LORENZ CLINIC

## Lorenz Clinic Professional Referral Form

Please fax this form and a Release of Information to (952) 361-5511.

To	<i>Lorenz Clinic</i>	From	
Lorenz Clinic Fax	<i>(952) 361-5511</i>	Organization Address	
Lorenz Clinic Phone	<i>(952) 443-4600</i>	Organization Zip Code	
Subject	<i>New Referral</i>	Date	

### CLIENT INFORMATION

First and Last Name	
Date of Birth	
Language Needs	
Parent/guardian name and phone (if client under 18)	
Parent/guardian name and phone	
Foster parent name and phone	

### PROFESSIONAL MAKING REFERRAL

Name	
Title	
Phone	
Email	

### SERVICES INTERESTED IN

- Early Childhood Day Treatment (*ages 3-7*)
- Community-Based Therapy (CTSS)
- Children's Intensive Behavioral Health Services (CIBHS)
- Young Adult IOP (*ages 18-20*)
- Adolescent IOP (*ages 13-17*)
- Children's IOP (*ages 8-12*)
- Outpatient Psychotherapy
- Psychiatric Medication Management

### ADDITIONAL NOTES:

*(i.e. client notes, preferred location, etc.)*

For any questions regarding the referral process, please call (952) 443-4600.