LORENZ CLINIC

Lorenz Clinic Professional Referral Form

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

To	*Lorenz Clinic*	From	
Lorenz Clinic Fax	*(952) 361-5511*	Organization Address	
Lorenz Clinic Phone	*(952) 443-4600*	Organization Zip Code	
Subject	*New Referral*	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	
Email Address	

PROFESSIONAL MAKING REFERRAL

Name	
Title	
Phone and Fax Number	
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.