A BETTER CONNECTION

1009 Hollinger Street Park Rapids, MN 56470

CTSS REFERRAL FORM

CTSS encompasses both Psychotherapy (with a licensed therapist) and Skills Training (with a mental health practitioner).
Please specify which you are referring for.

☐ **Psychotherapy**

☐ **Skills Training**

First Name: _____ **Last Name:** _____

Gender: _____ **Age:** _____ **DOB:**_____

Address: _____

City: _____ **Zip Code:**_____ **County:** _____

Insurance Company:_____ **ID #**:_____

Parent/Guardian Name(s):_____

Contact Phone Number: _____

Referral Source: _____ **Agency:** _____

Referral Phone: _____ **Email:** _____

ROI Attached?: Y / N

Current Diagnostic Assessment (within 1 year): Y / N **Attached?:** Y / N

Diagnostic Assessment includes the medical necessity to receive CTSS services?: Y / N

Preferred Days and Times: _____

Goals to be addressed: _____

_____

Additional Comments/Information: _____

_____

Please Fax Referral Form to (218)-732-4695
or
Email to Katie: katie@abetterconnectioninc.com

Contact Katie with any questions.