Nystrom & Associates, Ltd. /Family Support Services Inc.
13045 Falcon Drive, Suite 100
Baxter, MN 56425

Referral for ICTS services

Send this form to Mollie Nelson: Fax # 218-829-7649 email: MNelson@nystromcounseling.com

CLIENT INFORMATION

Name of Client: _____ Male: □ Female: □

Address: _____ Apt #: _____

City: _____ State: _____ Zipcode: _____

SSN: _____ DOB: _____

Home Phone: _____ Cell Phone: _____

INSURANCE INFORMATION

MA □ PMAP □ Commercial □ None □ Other □ Number: _____

CLIENT'S MENTAL HEALTH INFORMATION

Diagnostic: _____ Assessment Completed: Yes: □ No: □

Author & Date Completed: _____

Diagnosis: Is Client Aware of dx? Yes: □ No: □

Is client currently under commitment? Yes: □ No: □ Expiration Date: _____

Hospitalizations: Yes: □ No: □ Number of admissions: _____ Most recent admission: _____

CLIENT'S AREA OF NEEDS

Community Intervention □ Medication Education □ Benefits Assistance □ Independent Living Skills □

Symptom Management □ Psycho-Social Rehab □ Self-Care □ Home Maintenance □

Vocational Functioning □ Social Functioning □ Medical/Dental Needs □ Other: _____

Please list other providers currently working with this client (include name and number):

Psychiatrist: _____ County Case Manager: _____

Therapist: _____ Primary Case Provider: _____

Other: _____

REFERENT INFORMATION

Name of Referent: _____ Agency: _____

Phone Number: _____ Date of Referral: _____

Is the client aware of the referral?: Yes: □ No: □