FRASER
Special needs ★ Bright futures®

PROFESSIONAL REFERRAL FORM

Submit by faxing form to 612-767-0243 or call 612-767-7222 with questions.

Client Information

Client Name:	
Client DOB:	
Client Phone Number:	
Language Needs:	
Client Address:	
Parent/Guardian Name:	

Referring Provider

Provider Name:	
Clinic Name:	
Clinic Phone Number:	
Who to contact regarding referral (If same as provider, leave blank)	
Follow up Preferences:	

☐ Contact provider when family makes contact with Fraser

☐ Contact provider if family does not make contact with Fraser

Client's Medical History *(Please attach any supporting medical documents)*

Current Medical Diagnosis (In next question: Do you have any provisional or rule out dx?

Current Medications:

Did the client fail any early childhood screenings? If yes, which ones?

Type of Service Referred

Please check type of services referring for:

☐ Diagnostic Assessment	☐ Day Treatment
☐ Psychological Testing	☐ ABA
☐ Neuropsychological Evaluation	☐ Speech Therapy
☐ Individual Therapy	☐ Feeding Therapy
☐ Family Therapy	☐ Occupational Therapy
☐ Group Therapy	☐ Physical Therapy
☐ Other (Please indicate):	

Check any of the Following that Apply:

☐ Aggressive or Disruptive Behavior	☐ Hallucinations/Delusions
☐ Autism Spectrum Disorder	☐ Inattention hyperactivity and impulsivity
☐ Anxiety/Depression	☐ Trauma and Chronic Stress
☐ Bi-Polar Disorder	☐ Traumatic brain injury
☐ Cognitive/Learning Issues	☐ Self Harm
☐ Developmental Delays	☐ Suicidal Ideation
☐ Other:	

Additional Comments: