Ellison Center
A place for growth, development, and reflection

Date of Referral: _____

Please check all the outpatient mental health services that you are currently requesting assistance with or would like additional information about:

☐ Individual ☐ Caregiver-Child ☐ Couples ☐ Family ☐ Other: _____

☐ In-Person ☐ Telehealth ☐ Either ☐ Other: _____

Reason for Referral: _____

_____

_____

Referral Source & Contact Info:_____

Client Contact Information:

First Name: _____ Last Name: _____ Sex: _____

Address: _____ Date of Birth: _____

City: _____ State: _____ Zip Code: _____

Email: _____ Phone Number: _____

OK to email? ☐ Yes ☐ No OK to Leave a message? ☐ Yes ☐ No

If Client is a Minor:

Legal Guardian/Caregiver(s) Name: _____

Guardian's preferred phone number: _____

Who is child currently living with? _____

Is the child age 3 and under? ☐ Yes ☐ No

Is the child in foster care? ☐ Yes ☐ No When did placement begin? _____

Has there been a recent trauma? ☐ Yes ☐ No If yes, describe briefly _____

Is the client covered by health insurance?

☐ Yes ☐ No ☐ Not Sure If yes, complete insurance information below

Insurance Company: _____

Name of Policy Holder: _____ Policy Holder Date of Birth:_____

Policy Number: _____ Group Number:_____

Clinician being referred to:

☐ Alison Erickson, MA, LICSW ☐ Anna Clavin, MA, LMFT, IECMH-E®

☐ Heather Trettel, MS, LMFT, IMH-E® ☐ Pam Walz, MS, LMFT, RPT, IMH-E®

☐ Tracy Schreifels, MS, LMFT, IMH-E® ☐ No Preference/First Available

Please complete all areas and fax to Ellison Center at (320) 406-1700

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