BLU CARE

Toll-free: (888) 517-5550 Fax: 612-440-2199

Intake Referral Form

Client Information

Client Name: _____ Age: _____ DOB: __/__/____ Gender: M ☐ F ☐

Address: _____ City: _____ ST: ____ Zip: _____

Home Phone: _____ Work/Cell Phone: _____

Emergency Contact Name_____ Emergency Contact#: _____

Insurance Information

Policy # _____ Group# _____

Insurance Provider: _____

Referral Information

Referral Source: _____ Agency/Division: _____

Phone: ( ) _____ (w/c) Fax: ( ) _____

Current Soc. Serv./Psych. Involvement: Yes, ☐ No ☐ If yes, please describe: _____

Current Diagnoses (if any): 1. _____ 2. _____

Current Concerns: _____

_____

Medications: _____

Reason for Referral: _____