BRIGHTER PATH CENTER
GUIDING STEPS FOR SUCCESS

**Phone number : 952-297-8607** **Fax: 952-666-5103**

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|---|---|
| Referring Physician: | Office Contact Name: |
| Patient Name: | Office Contact Number: |
| Address: | |
| Age: DOB: | |
| Date of Referral: | |
| Home Phone: | Cell Phone: |
| Work Phone: | Fax #: |

| | |
|---|---|
| Primary Insurance: | |
| Employer: | |
| Policy Holder: | |
| DOB: | ID #: |
| Group #: | Benefits #: |

| | |
|---|---|
| Secondary Insurance: | |
| Employer: | |
| Policy Holder: | |
| DOB: | ID #: |
| Group #: | Benefits #: |

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| Previous Mental Health Counseling: |
| Prychotropic Medications Currently Prescribed: |

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| Parent/Guardian Name: |
| Requested Therapist (if any): |

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|---|---|---|---|
| Primary Reason for Referral: | ☐ Diagnosis | ☐ ABA therapy | ☐ General Inquiry |
| Specific Testing Requested: | ☐ ADOS | ☐ Other | |
| Physician Signature: | | | Date |

**For Internal Use Only**

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|---|
| Therapist In-Network: |
| Appt Date and Time: |