



11280 86th Avenue, Maple Grove, MN 55369
www.behavioralhealthmn.com

Healthwise Fax Referral Form

Please fax this form and we will contact the patient to schedule

Fax 763-400-7444

Referring Physician/Provider: _____ Phone: _____

Patient Name: _____ DOB: _____

Patient's phone: _____ email: _____

Insurance: _____

Type of Referral:

Therapy: Individual Couples Family Group

Biofeedback

Psychological Evaluation – Please check areas you feel need assessment:

General mental health/diagnosis

Anger

ADHD/ADD

Mood and personality

Cognitive and IQ

Behavioral functioning

Chronic pain

Learning disability

Other: _____

Neuropsychological Evaluation

Reason for Referral:

