Main Street
FAMILY SERVICES

Family Services Referral Form

Date of Referral:	

Referring Party Information	
Referring Party Name and Address:	
Referring Party Agency:	
Referring Party Phone Number(s):	
Referring Party Email:	

Identified Client
Name:

Parent(s) Information			
Parent 1		Parent 2	
Name:		Name:	
Address:		Address:	
Phone Number:		Phone Number:	
Email:		Email:	
Marital Status:		Marital Status:	
Date of Birth		Date of Birth	

Child(ren) Information			
Name	D.O.B.	Gender	Placement(s) (ex. Foster care, Kinship, etc.)

Address for child(ren) if different from parent(s)	
Caregiver Name:	Caregiver Name:
Address:	Address:
Phone:	Phone:
Email:	Email:

Main Street Family Services
MainStreetFamilyServices.org
administrator@mainstreetfamilyservices.org

Main Office
400 Jackson Ave
Elk River, MN 55330

Please state reason for referral:

Services Requested (Check as many as apply)					
☐	Therapeutic Services	☐	Parenting Skills		
☐	Supervised Visits	☐	Visits & Parenting Skills	☐	Transportation

Time of Day					
☐	Morning	☐	After School	☐	Evening

Number of visits per week and length of visit(s)	
Number per week:	Length:

Is there an approved location for the visit? If so where?
Location:
Would you like the visits to be at Main Street? ◯ Yes ◯ No

Issue(s) Check all that apply. List person(s) involved			
☐	Alcoholism	☐	Neglect
☐	Other CD	☐	Physical Abuse
☐	Parent/Child Conflict	☐	Emotional Abuse
☐	Financial/Legal Problems	☐	Domestic Violence
☐	Marital Conflict	☐	Physical Disability
☐	Limited Support System	☐	Developmental Disability
☐	Poor Home Management Skills	☐	Medical Problems
☐	Mental Illness/SED	☐	Other
☐	Ability to Nurture	☐	Medication
☐	Parent(s)	☐	Sexual Abuse

Type of Case					
☐	Voluntary	☐	Court Ordered	☐	Diagnostic Assessment

Case Plan/Releases
Is there a Case Plan in place? ◯ Yes ◯ No If yes, please attach a copy.

Please attach a copy of the release of information form signed by the client when applicable.