Healing in Harmony
MUSIC THERAPY SERVICES

Music Therapy Referral Form

Patient/Client's Demographic Information:

Client's Name: _____
Client's Primary Caregiver's Name: _____
Home Address: _____
City:_____ **State:**_____ **Zip:** _____
D.O.B: _____
Gender: _____
Phone Number: _____ **Cell:** _____ **Work:** _____
Email Address:_____

Diagnosis and Medical History:

Diagnosis: _____
Date and type of latest medical evaluation: _____
Current medications:
_____
_____

Funding Source: Please check appropriate circle and list type/name

- O **Grant** _____
- O **Scholarship** _____
- O **Out-of-pocket/private pay**_____
- O **Waiver** _____
- O **Other** _____

Contact information for FMS:

Name of FMS _____ **Contact Person:** _____

Phone Number: _____ **Email:** _____

Referring Physician/Social Worker/Parent/Primary Caregiver/Individual:

Name: _____
Name of organization/clinic/facility/school: _____
Contact phone number: _____
Contact email: _____
Preferred means of communication: please check one circle

- **O Email**
- **O Phone (call or text)**

Reason for referral:

Skill(s) to be addressed:

_____

_____

Interested service (select all that apply):

- **O Individual session**
- **O Sibling session**
- **O Adaptive guitar lesson**
- **O Adaptive singing lesson**
- **O Adaptive piano lesson**
- **O Family session**

Desired Session Length: _____ **Desired Frequency:** _____ **Best time:** _____
Other important considerations/musical preferences:

_____

_____

Thank you for your interest in our services. For questions, please contact us by email at healinginharmonyMT@gmail.com or by phone at (320)-226-3157. I look forward to seeing you soon!