



Medical Referral Form

Due to Medical Assistance and Minnesota Care and other insurance company's policies, a referral is needed from a primary care physician in order for a child to be seen by another provider. This form gives PORT Group Homes permission to have the child named below receive services at the local facilities available to PORT for any medical needs that may occur. This referral will remain in effect only while the child is residing at PORT Group Homes.

I authorize/refuse/deny referral of _____ (DOB: _____),
(Circle One) (Resident)
to facilities listed below for any medical or therapeutic services that may be necessary during placement at PORT Group Homes.

Doctor's Signature

Date

Medical Facility

Phone Number

Below is a list of facilities that residents may receive services from during their stay at PORT.

_____ Brainerd Medical Center (clinic)

_____ St. Joseph's Medical Center

_____ Brainerd Eye Care

_____ Dr. Moen/Dr. Mattson/Dr. Carlson, DDS

_____ Northern Orthopedics

_____ Adapt of Minnesota - outpatient chemical dependency treatment services

_____ Other _____
(List facility)

Please check one of the following:

Reason for refusal:

Reason for denial: