

**BLUE PLUS MSHO - MUSIC THERAPY REFERRAL**

Please complete the form & email to referrals@alliancemusictherapy.com

**Date:**

**Member Name:**       **MSHO Member ID:**

**DOB:**       **Age:**        **Gender:**

**Living Arrangement:** [ ]  Skilled Nursing Home [ ]  Customized Living [ ]  Adult Foster Care

**Diagnosis/reason for referral:**

[ ]  Dementia/Alzheimer’s [ ]  Cognitive support; memory care [ ]  Coping skill support

[ ]  Anxiety/agitation [ ]  High risk of isolation [ ]  Depression

[ ]  Social engagement [ ]  Symptom management (pain, nausea, other discomfort)

[ ]  Other:

**Facility information:**

Facility Name:

Address:

Facility Contact Name:       Email:       Phone:

*\*\*Note: Please notify Facility Contact that Alliance Music Therapy will contact them for set-up\*\**

**Guardian/POA**

Name:       Email:       Phone:

**Referring Care Coordinator**

Name:       County/Agency:

Email:       Phone:

**Requested frequency of visits if known (benefit includes 26 sessions per year):**

[ ]  Weekly [ ]  Biweekly [ ]  1x/Month [ ]  Other:

**Music/song preferences (if known):**

**Additional information**: (e.g. critical information for therapist to know for scheduling, communication barriers, cultural or background information you think may be helpful)

Thank you. Any questions? Contact Alliance Music Therapy at

612-584-0919, referrals@alliancemusictherapy.com