

**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