Please mail referrals to:
Living Spirit Therapy Services, LLC
2518 Longview Dr
New Brighton, MN 55112

LIVING SPIRIT
THERAPY SERVICES, LLC

Music Therapy Referral & Background Information

Client Name: _____
(Last) **(First)**

Address/Facility Name: _____

Address/Facility Location: _____

Room Number: _____ **DOB:** _____ **Age:** _____ **Special Directions for Unit:** _____

Desired Session Length: _____ **Desired Session Frequency:** _____ **Best Time for Sessions:** _____

☐Session length and frequency flexible. May adjust session length and frequency to meet client's immediate needs:
Maximum session frequency if flexible: _____ Maximum Session Length if flexible: _____

Diagnosis: _____

_____

Medications/Side Effects That We Should Be Aware Of: _____

Limits to Communication: ☐HOH ☐Uses Hearing Aids ☐Wears Glasses ☐Blind, Glaucoma, or Macular Degeneration
☐Aphasic. Type & Location of Stroke or TBI if Applicable: _____

☐Uses Adaptive Communication Device: _____ Other: _____

Physical Limitations: Needs: ☐ Wheelchair ☐ Walker ☐ Cane ☐ Assist From Staff to Transfer
☐ Assist From Staff to Reposition ☐ Impaired Limb Mobility:_____
☐ Other: _____

Mental Status: ☐ Alert ☐ Oriented x____ ☐ Confused ☐ Unresponsive ☐ Other: _____

Marital Status: ☐ Married Spouse Name: _____ ☐ Divorced ☐ Widowed ☐Single

Religion: _____ **Cultural Background:** _____

Past Professions: _____

Reason for Referral

☐ Quality of Life	☐ Personal Choice	☐ Successful Experiences	☐ Interest/Self Esteem/Self Identity
☐ Pain/Discomfort	☐ Dyspnea	☐ Nausea/Vomiting	☐ Range of Motion/Circulation
☐ Mood Problems	☐ Self Expression	☐ Life Review/Reminiscence	☐Strength and Endurance
☐ Emotional Support	☐ Spiritual Support	☐ Coping-Patient	☐ Coping-Family/PCG
☐ Tension/Contractures	☐ Isolation	☐ Structure Social Interaction	☐ Improve Communication
☐ Developmental Goals	☐ Academic Development	☐Cognitive Functioning	☐ Physical Rehabilitation
☐ Palliative Care	☐ Hospice	☐ Premorbid/Actively Dying	☐ Decrease Fear/Anxiety
☐ Memory Problems: (Circle) Short, Long Term		☐ Agitation/Behavior Issues _____	

☐ **Enhance Other Therapies: (**Circle) PT, OT, SLP, and/or Restorative Program
Therapist(s) Name and Number: _____

Music Background (if any)

☐ Vocal _____ ☐ Played Instrument: _____ ☐ Dancer

☐ Other: _____

Preferred Music

☐ Hymns ☐ Gospel ☐ Spirituals ☐ Contemporary Christian ☐Blues ☐ Country/Western ☐ Old Time Popular

☐ Broadway ☐Classical ☐ Jazz ☐ Bluegrass ☐ Folk/Traditional ☐ R & B/Soul ☐ Rock ☐ Patriotic

☐ Big Band/Swing ☐ Ethnic _____

☐ Popular (Circle): ☐ 20s ☐ 30s ☐ 40s ☐ 50's ☐ 60's ☐ 70's ☐ 80's ☐ 90's ☐ 00's ☐ Current

Other: _____

Favorite Musicians: _____

Favorite Songs: _____

Does Not Like: _____

Comments: _____

Please provide any additional requests or information that may be helpful. _____

_____

_____

Contact Person (for updates and documentation):

Name: _____ Relationship to client: _____

Address: _____

Phone Number: _____ Email: _____

☐ Updates via phone ☐ Updates via mail ☐ Updates via communication book ☐Updates via email (requires additional consent)

Bill

☐ Family/Conservator/Contact Person ☐ Facility Trust ☐ Fiscal Management Services (FMS): Type of Waiver: _____

For FMS

Name of FMS: _____Contact Person: _____

Phone Number: _____Email: _____

Address: _____

Referred By

_____

Name **Title** **Date**