



10/31/2022

Welcome!

My name is Amanda Dwinell and I am a licensed therapist with MoveFwd. Our agency provides free therapy and case management services for youth ages 12-24 in the western suburbs. I am excited to partner again with St. Louis Park Middle School to offer groups this year.

Starting in early November, I will be facilitating a weekly psychoeducational support group at SLP Middle School for students experiencing changes within their family. This 45 minute group aims to support students in learning how to cope with transitions and build social support.

Topics will include: identifying changes, managing emotions, family timeline reflection, self esteem and identity, grief and loss, family communication, expressing myself, self care, looking ahead, and building social support. Adjustments can be made based on the needs and preferences of the group.

Please look over the enclosed MoveFwd Handbook. If you agree to your child participating in the group, please sign the consent form and release of information and return to the school. The handbook is yours to keep. I have been coordinating with the school social worker, Kristen Engen-Routzon, 952-928-6389. Please feel free to reach out to either of us with any questions. Thank you!



MoveFwd
Eisenhower Community Center
1001 Highway 7, Room 237
Hopkins, 55305

952/988-TEEN (8336)

movefwdmn.org

Amanda Dwinell, MA, LPCC
Clinical Manager/Therapist, MoveFwd
952-988-5356
amanda@movefwdmn.org

MoveFwd Consent

I have received the Participant Rights and Responsibilities. I know that I can review it at any time with my therapist or case manager.

Print Name

Signature

Date

I hereby give consent for therapy and/or support services at MoveFwd with my child listed below. I understand that I can contact the therapist or case manager working with my child if I have any questions or concerns. I also understand that I can revoke this at any time, but I must do it in writing. This consent will automatically expire after one year.

Parent/Guardian Signature

Date

Parent/Guardian Printed Name

Relationship to Child

RELEASE OF INFORMATION

Name of Participant:

Date of Birth:

Address: _____

City State Zip

This will authorize:

Name: Amanda Dwinell, LPCC

Title: Therapist

MoveFwd

1001 Hwy 7, Rm 237

Hopkins, MN 55305

Phone: 612-799-7335

To release to and receive information from:

Name: Kristen Engen-Routzon and support staff

Title: Social Worker, Counseling Office

Organization: St. Louis Park Middle School

Address: 2025 Texas Avenue S

St. Louis Park, MN 55426

Phone: 952-928-6389

This information is needed for the following purpose(s):

Coordination of care, group scheduling, general progress, concerns

You have the right to refuse to release information. You may revoke consent upon written notice. This consent will automatically expire at the end of one year from the signed date.

Participant signature: _____ Date: _____

Parent/Guardian: _____ Date: _____

MoveFwd staff signature: _____ Date: _____

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