Make a Referral

Mental Health /Behavioral Health Services

Name of referred person _____ Birthdate _____ Gender M ○ F ○

Address _____ City _____

State _____ Zip Code _____ Phone _____

Services you are seeking:

- o *Adult Mental Health Services*
- o *Diagnostic Assessment*

Primary diagnosis (if known) _____

Reason for referral

Current living situation:

- ○ Private Home/Apt.
- ○ Foster Care
- ○ Board & Lodge
- ○ IRT
- ○ RTC
- ○ Nursing Home
- ○ Homeless/Shelter
- ○ Jail/Prison
- ○ Other

Guardian (if any) _____ Phone _____

Case manager/agency (if any) _____ Phone _____

Name & agencies of other Mental Health/Behavioral Health providers:

Insurance/health care type:

- ○ Medical Assistance
- ○ MinnesotaCare
- ○ VA
- ○ Medicare
- ○ Private/Commercial
- ○ None

Insurance carrier (ie. Medica) _____ Insurance ID number _____

Requested start date _____

Name person making request _____ Phone _____

Relationship to referred person _____

How best to contact:
(list whom to contact, days, hours, times & phone numbers where it is best to reach them)

Signature _____ Date _____