##### Referral Form



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| --- | --- | --- | --- | --- |
| *Grand Rapids* | *Grand Rapids Outpt* | *Deer River* | *Bemidji* | *Duluth* |
| *1880 River Rd* | *413 SE 13th St, Ste A* | *313 E Main Ave* | *4225 NW Technology Dr* | *324 W Superior St, Ste 150* |
| *Grand Rapids, MN 55744* | *Grand Rapids, MN 55744* | *Deer River, MN 56636* | *Bemidji, MN 56601* | *Duluth, MN 55802* |
| *218-327-3000(ph)* | *218-999-9908(ph)* | *844-466-3720(ph)* | *218-751-0282(ph)* | *218-733-3000(ph)* |
|  | *218-999-9959(fax)* | *218-246-9849(fax)* | *218-751-0870(fax)* | *218-733-3079(fax)* |

###### 

Select One:  Diagnostic Assessment  Medication Management  Individual Psychotherapy  Family Therapy  CD Services

Children’s Therapeutic Services and Support (CTSS) Adult Rehabilitative Mental Health Services (ARMHS)

Targeted Case Management (TCM)

|  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |
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| **Referral Source (person’s name):** | | | | | | | | | | | | | | | | | | **Phone #:** | |
| **Client Name:** | | | | | | | | | | | | | | | **DOB:** | | | **SS#:** | |
| **Address:** | | | | | | | | | | | | | **City:** | | | | **County:** | | |
| **State:** | | **Zip Code:** | | | | **Home Phone: ( )** | | | | | | | | | **Work Phone: ( )** | | | | |
| **Age:** | **Sex:** | | | **School:** | | | | | | | | | | | | | | **Grade:** | |
| **Ethnicity:** | | | | | | | | **Tribal Affiliation:** | | | | | | | | | | **Religion:** | |
| **Check One:** | | | **Parent(s):** | | **Guardian(s):** | | | | | **Name(s):** | | | | | | | | | |
| **Address:** | | | | | | | | | | | | | | | | **Home Phone: ( )** | | | |
| **City:** | | | | | | | **State:** | | | | **Zip Code:** | | | | | **Work Phone: ( )** | | | |
| **County:** | | | | | | | | | **Sex:** | | | | | **Relationship:** | | | | | |
| **Other Children Living in the Home** | | | | | | | | | **Age** | | | **Other Children Living in the Home** | | | | | | | **Age** |
| 1. | | | | | | | | |  | | | 3. | | | | | | |  |
| 2. | | | | | | | | |  | | | 4. | | | | | | |  |
| **Present Interventions/Services Being Provided to the Family** | | | | | | | | | | | | | | | | | | | |
| Case Manager/Social Worker: | | | | | | | | | | | | | Children’s Mental Health Worker: | | | | | | |
| Outpatient Mental Health Agency: | | | | | | | | | | | | | Outpatient Mental Health Provider: | | | | | | |
| C.D. Treatment Agency: | | | | | | | | | | | | | C.D. Treatment Provider: | | | | | | |
| Probation Agency: | | | | | | | | | | | | | Probation Officer: | | | | | | |
| Psychiatric Service Agency: | | | | | | | | | | | | | Psychiatric Service Provider: | | | | | | |
| Current Foster Home: | | | | | | | | | | | | | Other Service Providers: | | | | | | |
| Current Pharmacy | | | | | | | | | | | | |  | | | | | | |
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| **Current Family Situation**: |
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| **Identified needs to be addressed and specific outcomes expected:** |
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***Below is intended for office use only***

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| Referral Received Date: | M.A. I.M. Care  Other  : | | | Ins. #: |
| Insurance Verification Date: | DA Requested: | Date DA Requested: | | D.A./Psych Eval Date: |
| Date Outside DA to MHP for Approval: | | Assigned MH Practitioner: | | |
| Developmental and mental health needs can be met by CTSS Services:  yes  no | | | Ok to Open: | |

FS-11 Referral Form (07/10)/TT 10/19