#####  Referral Form



|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| *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