REFERRAL FORM

Check Location:

☐ Bloomington Location:
2740 American Blvd West, Suite100
Bloomington, MN 55431

☐ Saint Paul Location:
One West Water Street, Suite 288
Saint Paul, MN 55107

CLIENT INFORMATION

Today's Date: ____ / ____ / ____ (MM / DD / YYYY)

Date of Birth: ____ / ____ / ____ (MM / DD / YYYY)

Name: _____

Client Address: _____

_____

_____

Home Phone: _____

Cell Phone: _____

Legal Guardian: _____

Insurance Coverage:

- ☐ Blue Cross Blue Shield
- ☐ Health Partners
- ☐ Medica
- ☐ Preferred One
- ☐ UCare
- ☐ Medical Assistance(MA)
- ☐ Others: _____

Insurance ID# _____

Group#: _____

Preferred Language: _____

Interpreter: ☐ Yes ☐ No

Referred by: _____ Agency/Division: _____

Phone: _____ Fax: _____

Reason for Referral: (Check all boxes that apply)

- ☐ Outpatient Mental Health
  - ☐ Individual
  - ☐ Couples
  - ☐ Family
  - ☐ Mental Health Evaluation
- ☐ ARMHS
- ☐ Outpatient Chemical Dependency
  - ☐ CD Track
  - ☐ MI/CD Track
  - ☐ Chemical Health Evaluation
- ☐ Driving With Care
  - ☐ Level 1 Education
  - ☐ Level 2 Education
  - ☐ Level 2 Therapy

Specify Track _____

Medical Information:

List Name and Date of Diagnosis (if any): _____

List Name and Date of Medications (if any): _____ Compliant: ☐ Y ☐ N

List of Food Allergies (if any): _____

Additional information you feel would be helpful:

**** IF CURRENT DIAGNOSTIC ASSESMENT AND/OR CHEMICAL EVALUATION IS AVAILABLE, PLEASE SEND ALONG WITH THIS REFERRAL FORM WITH SIGNED RELEASES OF INFORMATION INCLUDED****

Please fax completed form to: (651) 788-7508

If we may be of further assistance call: (651) 414-0063

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