Reach for Resources, Inc.

DEPARTMENT OF MENTAL HEALTH SERVICES
COUNSELING REFERRAL FORM

Return completed form to Lisa Rivers at lrivers@reachforresources.org (preferred) or 952-229-4468 (fax)

DATE OF REFERRAL: _____ REFERRED BY/RELATIONSHIP: _____

AGENCY & ADDRESS: _____

PHONE: _____ FAX: _____ EMAIL: _____

CLIENT GENERAL INFORMATION

NAME: _____ DOB: _____ SSN: _____ MA #: _____

ADDRESS: _____ CITY/STATE/ZIP: _____

PHONE: _____ GENDER: ◯ MALE ◯ FEMALE ◯ TRANSGENDER

IS THIS INDIVIDUAL HIS/HER OWN GUARDIAN?

◯ YES ◯ NO: _____

IS THIS INDIVDIUAL AWARE OF THIS REFERRAL? ◯ NO ◯ YES

RACE/ETHNICITY:

☐ CAUCASIAN/WHITE
☐ AFRICAN AMERICAN/ BLACK
☐ AMERICAN INDIAN/ ALASKA NATIVE
☐ LATINO/A
☐ NATIVE HAWAIIAN/ PACIFIC ISLANDER
☐ ASIAN

REASON FOR REFERRAL / AREAS INDIVIDUAL WANTS TO ADDRESS:

ADDITIONAL NOTES: