Reach for Resources, Inc.

DEPARTMENT OF MENTAL HEALTH SERVICES ARMHS REFERRAL FORM

Return completed form to Jessica Cermak at jcermak@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/PMI: _____

ADDRESS: _____ CITY/STATE/ZIP: _____

PHONE: _____ GENDER: ◯ MALE ◯ FEMALE ◯ TRANSGENDER

RACE/ETHNICITY:

☐ CAUCASIAN/WHITE ☐ AFRICAN AMERICAN/ BLACK

☐ AMERICAN INDIAN/ ALASKA NATIVE ☐ LATINO/A

☐ NATIVE HAWAIIAN/ PACIFIC ISLANDER ☐ ASIAN

IS THIS INDIVIDUAL HIS/HER OWN GUARDIAN?

◯ YES ◯ NO: _____

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

DAY TREATMENT OR WORK SCHEDULE? ◯ NO ◯ YES: _____

OTHER SERVICES RECEIVING:

☐ CASE MANAGEMENT: _____

☐ ILS/WAIVERED SERVICES: _____

☐ SUPPORTED EMPLOYMENT _____

DOES THIS INDIVIDUAL HAVE A STAFF PREFERENCE? ◯ MALE ◯ FEMALE ◯ NO PREFERENCE

MENTAL HEALTH INFORMATION

MENTAL HEALTH DIAGNOSIS(ES): ☐ MAJOR DEPRESSION ☐ BIPOLAR DISORDER ☐ BORDERLINE PERSONALITY DISORDER

☐ SCHIZOPHRENIA ☐ SCHIZOAFFECTIVE DISORDER ☐ OTHER: _____

COGNITIVE IMPAIRMENT: ☐ BORDERLINE IQ ☐ MILD MR ☐ LEARNING DISABILITY

PSYCHIATRIST & CLINIC: _____ PHONE: _____

ADDRESS: _____ FAX: _____

THERAPIST & CLINIC: _____ PHONE: _____

ADDRESS: _____ FAX: _____

PLEASE INCLUDE THE FOLLOWING DOCUMENTATION IF POSSIBLE:

MOST RECENT DIAGNOSTIC ASSESSMENT, PSYCH EVALUATION, FUNCTIONAL ASSESSMENT

ARMHS GOALS FOR THIS INDIVIDUAL/ REASON FOR REFERRAL:	
ADDITIONAL NOTES:	