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:	