



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 OTHER RACE/ ETHNICITY: AFRICAN AMERICAN/BLACK ASIAN
IS THIS INDIVIDUAL HIS/HER OWN GUARDIAN? CAUCASIAN/WHITE LATINO/A
YES NO: \_\_\_\_\_ AMERICAN INDIAN/ALASKA NATIVE
IS THIS INDIVIDUAL AWARE OF THIS REFERRAL? NO YES NATIVE HAWAIIAN/PACIFIC ISLANDER
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

\*please note we currently only have female practitioners

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: \_\_\_\_\_
DO YOU HAVE MENTAL HEALTH RECORDS FOR THIS INDIVIDUAL? NO YES (PLEASE ATTACH)

NOTE: Diagnostic Assessment completed within one year of ARMHS intake must be obtained. Attachment of this document can expedite service start date.

Table with 2 columns: ARMHS GOALS FOR THIS INDIVIDUAL/ REASON FOR REFERRAL; ADDITIONAL NOTES