Children's Mental Health Targeted Case Management
Referral Form

Client Name: ____ **Date of Referral:** _______________

Referred by: __________________________ **Company:**____

Phone: _______________ **Fax:**_______________ **Email:**____

Birthdate:_________ **Age:**_____ **Grade:**_____ **SSN:**_______________ **Race:**____________________________________

Parent/Guardian:__________________________ **Phone:** _______________ **Email:**____________________________

Address:____

Health Insurance Company:______________________________ **Medical Assistance (PMI Number):**_______________

Policy Number:___________________________ **Group Number:**____________

Policy Holder's Name:_____________________________ **Birthdate:**___________

Does the client have a current diagnosis (diagnosed within the last year)? ☐ Yes ☐ No

If yes, please list diagnosis and date/source of data:

Date: ___________ **Source of data:** _____________________________________

Diagnosis:____

**Please include copy of current Diagnostic Assessment if possible.

What problems does client/family need help with?

Which services are needed to resolve problems?

Therapist:______________________________________ **Company/Clinic:**____________________________________

Phone:_______________ **Fax:**_______________ **Email:**____

Psychiatrist:____________________________________ **Company/Clinic:**____________________________________

Phone:_______________ **Fax:**_______________ **Email:**____

Please send referral form and current diagnostic assessment to:

Jessica Cermak
Managing Director of Mental Health Services
jcermak@reachforresources.org
952-229-4468 (FAX) | 952-737-2980 (Direct)