



REFERRAL FOR MENTAL HEALTH SERVICES

Client Name [ ] DOB [ ] Gender [ ]

Client Address [ ]

Social Security No [ ] Phone [ ] County of Residence [ ]

Parent/Guardian Name(s) [ ] Phone [ ]

Referred by:

Agency [ ] Name [ ] Phone [ ]

Case Manager Name: [ ] County [ ] Phone [ ]

Insurance (List primary & secondary) Insured Name Insurance ID (include copy of cards)

Interpreter needed/ language: [ ]

Primary care physician: [ ] Phone [ ] Last seen [ ]

Other mental health provider [ ] Phone [ ] Last seen [ ]

Diagnostic Assessment and Psychological Evaluation: Note: After review & intake session new DA may be scheduled.

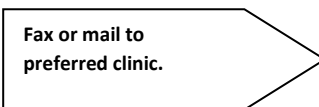
- A current diagnostic assessment is attached. A psychological evaluation has been completed. SPMI Other Eval is included with this referral.

Please indicate services requested:

- Outpatient Therapy, Psychiatric / Medication Management, CTSS (Children's Therapeutic Services & Support), Anger Management, Domestic Abuse Intervention Program (DAIP), Diagnostic Assessment, ARMHS (Adult Rehabilitative Mental Health Services), School Linked Mental Health Services, OP, CTSS.

Describe reason for referral or question to be answered by psychological evaluation. Attach sheet if necessary. You may be contacted if more information is needed.

[ ]



1407 S. State Street New Ulm, MN 56073 Phone: 507-354-3181 Fax: 507-354-3183
709 S Front Street, Ste 2 Mankato, MN 56001 Phone: 507-388-3181 Fax: 507-388-3199

Referred by signature: [ ] Date: [ ]

INTERNAL USE ONLY: Date Received [ ] By FDE [ ]

NURSE USE ONLY: Approved for Urgent Care (RN signature): [ ] Date: [ ]
Rational for Urgent Care/Client is experiencing the following:
Significant symptoms (Unable to go to work, school, or self-care, tremors etc.)
New or increased side effects (out of the expected side effects)
Suicidal, self-injurious or homicidal ideation, plan or intent
Running out of medications
Recently hospitalized
Other: [ ]

Date  To  Note