Southern Minnesota BEHAVIORAL HEALTH

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. ☐ SPMI ☐ Other

☐ A psychological evaluation has been completed. ☐ Eval is included with this referral.

Please indicate services requested:

☐ Outpatient Therapy ☐ Diagnostic Assessment

☐ Psychiatric / Medication Management ☐ ARMHS (Adult Rehabilitative Mental Health Services)

☐ CTSS (Children's Therapeutic Services & Support) ☐ School Linked Mental Health Services

☐ Anger Management ☐ OP ☐ CTSS

☐ Domestic Abuse Intervention Program (DAIP)

☐ Assessment ☐ Group ☐ Both

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.

_____

_____

Fax or mail to preferred clinic.

☐	**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