515 Bridge Street East
Park Rapids, MN 56470
218 366-9229 phone
218 237-2520 fax

Adult Rehabilitative Mental Health Services (ARMHS)
Referral Form

Person Making Referral: ______________________________ Agency: ______________________________

Date Referred: ______________________________ Agency Phone: ______________________________

Client Name: ______________________________ Date of Birth: ______________________________

Client Phone: ______________________________ Best Time to Contact: ______________________________

Client Address: ____

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DA Date: ______________________________ DA Completed by: ______________________________

Diagnosis: ____

Client Goal Areas (circle all that apply):

Medical	Dental	Chemical Use
Employment	Education	Housing
Financial	Social Skills	Independent Living Skills

Other (please list): ____

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Is referring Clinician willing to participate in treatment planning with client, ARMHS Clinical Supervisor and ARMHS Practitioner: Yes No Is WHODAS Completed? Yes No

Funding Source: MA CSP Other: ______________________________

Funding Verified by: ______________________________ Date Verified: ______________________________

LCA Client ID #: ______________________

Client Referred to (Practitioner): ______________________________ Date: ______________

Clinical Supervisor's Signature: ______________________________ Date: ______________