11 NW Main Street
Menahga, MN 56464
218 564-9229 phone
218 237-2520 fax

Substance Use Disorder Services
Referral Form

Date: ____________

Person Making Referral: ________________________________ Agency: _____________________________

Agency Phone: ____________________________ Client Name: _____________________________________

Date of Birth: ______________________________ Client Phone: ____________________________________

Best Time to Contact: ________________________________ Homeless? ☐ Yes ☐ No

Client Address: ____

Why Referring? ____

____

Previous: ☐ Diagnostic Assessment ☐ Rule 25 Assessment ☐ Comprehensive Assessment

If any assessments have been completed, we will need a copy.

Where: ____ When: ___________________________

Where: ____ When: ___________________________

Court Ordered? ☐ Yes ☐ No Which County? ________________________________

	Name	Phone Number	County
Probation Officer			
Case Manager			
CHIPS Worker			

*If Court-Ordered, a copy of the Order must be brought to the office before the appointment can be scheduled to ensure proper services will be provided. At that time client can sign ROI to PO or Court.

Primary Insurance: ____________________________ Secondary Insurance: _________________________

Current Provider Name	Where	Reason

---For LCA use only ---

SUDS Date Reviewed: ___________ ☐ Accept ☐ Refer Assigned Clinician: __________________

Scheduled On: __________________________ Site: _______________ Service Type: ________________