Adult Rehabilitative Mental Health Services (ARMHS)
CSP / ICTS

Referral Form

Person making referral: _____ Agency: _____

Date referred: _____ Agency phone: _____

Client Name: _____ DOB: _____

Client Phone: _____ Best time to contact: _____

Client address: _____

Location: ☐ Park Rapids ☐ Bemidji

***Have they had a Diagnostic Assessment in the last year? ☐ Yes ☐ No**

Date of DA: _____ Who completed DA: _____

Agency: _____ Diagnosis: _____

****Whenever possible please include the Diagnostic Assessment w/the referral.***

Client goal areas:

☐ Medical	☐ Dental	☐ Chemical Use
☐ Employment	☐ Education	☐ Housing
☐ Financial	☐ Social skills	☐ Independent living skills

Other (please list): _____

_____

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

Funding source: ☐ MA ☐ CSP ☐ ICTS Other: _____

----------For LCA use only----------

Funding verified by: _____ Date verified: _____

LCA client ID#: _____

Client referred to (Practitioner): _____ Date: _____

Clinical Supervisor's signature: _____ Date: _____