



Adult Rehabilitative Mental Health Services (ARMHS) CSP / ICTS

Referral Form

Person making referral: _____ Date referred: _____

Agency: _____ 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:

- | | | |
|-------------------------------------|--|--|
| <input type="checkbox"/> Medical | <input type="checkbox"/> Dental | <input type="checkbox"/> Chemical Use |
| <input type="checkbox"/> Employment | <input type="checkbox"/> Education | <input type="checkbox"/> Housing |
| <input type="checkbox"/> Financial | <input type="checkbox"/> Social skills | <input type="checkbox"/> 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: _____