MINNESOTA CENTER FOR PSYCHOLOGY

ARMHS REFERRAL FORM

Person Making Referral: _____ Date: _____

Agency: _____ Phone #: _____

Client Name: _____ County of Residence: _____

County of Financial Responsibility: _____

Address: _____ Client Phone #: _____

_____ Date of Birth: _____

Social Security #: _____ Guardian/Conservator Status: _____

Guardian/Conservator Name: _____ Guardian/Conservator Phone #: _____

Race: _____ Hispanic? Yes ☐ No ☐

MA ☐ GAMC ☐ MNCare ☐ PMI #: _____

Medicare? ☐ NO ☐ YES HIN (Medicare) #: _____

Other Insurance? ☐ NO ☐ YES; If Yes List Type and Policy Number:

Type **Policy Number**

_____ _____

List Mental Health Services client receives (Psychologist, Psychiatrist, DBT, CSP, etc.)? Indicate N/A if none.

_____ _____

_____ _____

Waivered Service Client Receives (e.g. CADI, TBI, MR/RC)? Indicate N/A if NONE. _____

Does the client have any of the following case managers? ☐ NO ☐ YES; If yes, specify:

CADI: _____ _____

Name Phone

Mental Health/Rule 79: _____ _____

Name Phone

See Back for additional information

FOR OFFICE USE ONLY

Date Received:		
EVS Contacted?	Date:	Status:

Date of Client's Last Diagnostic Assessment/Psychological Evaluation: _____

Diagnostic Codes: _____

If a new DA is needed, would client like anyone present at assessment? _____

Please attach the latest copy of an assessment or evaluation to the referral, if available.

How could this client benefit from ARMHS?

Special Needs of Client? (ie. male/female practitioner, days/times available to meet, etc)

Other information that may be helpful in providing ARMHS?

Does the client have any pets in the home? (If yes, please list type below)*

*To help determine if a provider with allergies will be able to work with them.