External Referral Form

SOLUTIONS
BEHAVIORAL HEALTHCARE PROFESSIONALS

Date of Referral: _____
Referring Person/Agency: _____ Phone Number: _____
Clients Name: _____ Date of Birth: _____
Clients Address: _____ Phone Number: _____
Guardian (If applicable): _____ Phone Number: _____

PLEASE SELECT TYPE OF REFERRAL

Minnesota				
☐	Case Management	☐ Child	☐ Adult	
☐	Outpatient	☐ Child	☐ Adult	
☐	Adult Rehabilitative Mental Health Services (ARMHS)			
☐	Children's Therapeutic Support Services (CTSS)			
☐	Early Intensive Developmental and Behavioral Intervention (EIDBI-Autism Spectrum Disorder)			
North Dakota				
☐	Mental Health Rehabilitation Services	☐ Child	☐ Adult	

PLEASE SEND REQUESTED INFORMATION TO THE OFFICE CHECKED BELOW.

☐	Moorhead, MN	891 Belsly Blvd, 56560	Ph. 218-287-4338	Fax. 218-287-5928
☐	Detroit Lakes, MN	1104 West River Road, 56501	Ph. 218-844-6853	Fax. 866-226-6130
☐	Fergus Falls, MN	806 East Fir Ave, Ste 200, 56537	Ph. 218-998-2992	Fax. 320-323-4357
☐	Alexandria, MN	512 30th Ave. E., Ste 100, 56308	Ph. 320-762-5411	Fax. 320-762-0829
☐	Sauk Centre, MN	508 Main Street S., 56378	Ph. 320-351-4871	Fax. 320-351-4871
☐	Waite Park, MN	423 Great Oak Dr., 56387	Ph. 320-281-5305	Fax. 320-281-5306
☐	Fargo, ND	1126 Westrac Dr., 58103	Ph. 701-412-2973	Fax. 701-237-4407

Presenting Problem (Reason for Referral):
Last known Diagnostic Assessment done on: By: (clinician/agency)
Diagnostic Code (s): Primary Diagnosis:
Please list any other services/providers currently working with client:
List any other special requests/concerns (physical disabilities, safety concerns, etc.):

PLEASE COMPLETE INFORMATION ON FOLLOWING PAGE IF APPLICABLE FOR REFERRAL TYPE

Signed: **Title:**

PLEASE FAX REFERRAL TO RESPECTIVE OFFICE CHECKMARKED ABOVE
ATTN: INTAKE
Attach DA if applicable

External Referral Form

Case Management

Serious and Persistent Mental Illness Diagnosis:
☐ 1) The recipient has undergone 2 or more episodes of inpatient care for mental illness within the preceding 24 months; or
☐ 2) The recipient has experienced a continuous psychiatric hospitalization or residential treatment exceeding 6 months duration within the preceding 12 months; or
☐ 3) The recipient has a diagnosis of schizophrenia, bipolar disorder, major depression, or borderline personality disorder, evidences a significant impairment in functioning, and has a written opinion from a mental health professional stating he/she is likely to have future episodes requiring inpatient or residential treatment, unless community services are provided; or
☐ 4) The recipient is currently under commitment by a court order as a person with mental illness under Minnesota Statutes or the person's commitment is under a stay/continuance for reason related to the person's mental illness.
☐ 5) The recipient was eligible under one of the above criteria, but the specified time has expired, OR the adult was eligible as a child and has a written opinion from a mental health professional (in the last three years) stating that the adult is reasonably likely to have future episodes requiring inpatient or residential treatment of the frequency listed in criteria (1) or (2) above unless ongoing case management or community support services are provided.

Adult Rehabilitative Mental Health Services (ARMHS)

Eligible clients MUST be on a PMAP or MN MA to receive services:
MA#: PMAP Insurance Name:
Please check all areas in which support is needed:

☐ Mental Health Symptoms ☐ Mental Health Service Needs ☐ Use of Drugs or Alcohol
☐ Vocational Functioning ☐ Educational Functioning ☐ Social Functioning
☐ Interpersonal Functioning ☐ Self-care/Independent Living ☐ Medical Health
☐ Dental Health ☐ Using Transportation ☐ Obtaining/Maintaining Housing
☐ Obtaining/Maintaining Financial Assistance ☐ Other:

Current living situation:
☐ Shelter ☐ Hospital ☐ Independent ☐ Group ☐ Home ☐ Other:

Children's Therapeutic Support Services (CTSS)

Childs Current Grade: Current School:
Child on an Individual Education Plan (IEP): ☐ Yes ☐ No Student MARS #:

Mental Health Rehabilitation Services – Skills Therapy

Mental Health Diagnosis: Axis I: Axis II:
Axis III:
Has this individual been hospitalized? ☐ No ☐ Yes
If yes, how many times in past 3 years?
Is individual at risk of out of home placement or hospitalization without rehab services? ☐Yes ☐ No
Has individual been in (please check if applies):
☐Residential Care ☐ Foster Care ☐ Other out of Home Placement:
List any other special requests/concerns (physical disabilities, safety concerns, etc.):

Desired outcome of services: