UBUNTU

DEPARTMENT OF MENTAL HEALTH SERVICES ARMHS REFERRAL FORM

Return completed form **WITH current Diagnostic Assessment (less than 8 months old)** to Marika Reese at marikareese@ubuntucareservices.com or via fax: (612) 465-3420

DATE OF REFERRAL: _____ REFERRED BY/RELATIONSHIP: _____

AGENCY & ADDRESS: _____

PHONE: _____ FAX: _____ EMAIL: _____

CLIENT GENERAL INFORMATION

NAME: _____ DOB: _____ SSN: _____ MA/PMI: _____

ADDRESS: _____ CITY/STATE/ZIP: _____

PHONE: _____ GENDER: MALE FEMALE RACE/ETHNICITY: AFRICAN AMERICAN/BLACK ASIAN

IS THIS INDIVIDUAL HIS/HER OWN GUARDIAN? CAUCASIAN/WHITE LATINO/A

YES NO: _____ AMERICAN INDIAN/ALASKA NATIVE

NATIVE HAWAIIAN/PACIFIC ISLANDER

IS THIS INDIVDIUAL AWARE OF THIS REFERRAL? NO YES

DAY TREATMENT OR WORK SCHEDULE? NO YES: _____

OTHER SERVICES RECEIVING: CASE MANAGEMENT: _____

ILS/WAIVERED SERVICES: _____

SUPPORTED EMPLOYMENT _____

DOES THIS INDIVIDUAL HAVE A STAFF PREFERENCE? MALE FEMALE NO PREFERENCE

MENTAL HEALTH INFORMATION

MENTAL HEALTH DIAGNOSIS(ES): MAJOR DEPRESSION BIPOLAR DISORDER BORDERLINE PERSONALITY DISORDER

SCHIZOPHRENIA SCHIZOAFFECTIVE DISORDER OTHER: _____

COGNITIVE IMPAIRMENT: BORDERLINE IQ MILD MR LEARNING DISABILITY

PSYCHIATRIST & CLINIC: _____ PHONE: _____

ADDRESS: _____ FAX: _____

THERAPIST & CLINIC: _____ PHONE: _____

ADDRESS: _____ FAX: _____

DO YOU HAVE MENTAL HEALTH RECORDS FOR THIS INDIVIDUAL? NO YES (PLEASE ATTACH)

ARMHS GOALS FOR THIS INDIVIDUAL/ REASON FOR REFERRAL:	
ADDITIONAL NOTES:	