

**Children’s Mental Health Programs Referral**

**Today’s date:** Click or tap to enter a date. **Choose Program:** Choose an item.

**Referred by:** Click or tap here to enter text. **Phone #:** Click or tap here to enter text.

**Client’s Name**: Click or tap here to enter text. Date of birth: Click or tap here to enter text.

**Gender:** M  F **Self injurious**: Yes  No **Suicidal**:  Yes  No **Interpreter:**  Yes  No

**Reason**: Click or tap here to enter text. Diagnosis (if known): Click or tap here to enter text.

**Legal Guardian:**  Click or tap here to enter text.  **Legal Guardian:** Click or tap here to enter text.

Relationship:  Parent  Foster Parent Other Relationship: Parent Foster Parent  Other

Address: Click or tap here to enter text. Address: Click or tap here to enter text.

Click or tap here to enter text. Click or tap here to enter text.

Phone Number: Click or tap here to enter text. Phone Number: Click or tap here to enter text.

Home  Cell  Work  Home  Cell  Work

Ok to leave Voicemail?  Yes  No Ok to leave Voicemail?  Yes  No

Email: Click or tap here to enter text. Email: Click or tap here to enter text.

**Insurance?: Yes  No If no, please contact your local county office and speak to a MNSURE navigator**

**Primary Ins.:**  Click or tap here to enter text. **Secondary Ins:**  Click or tap here to enter text.

MA  PMAP  Commercial  MA  PMAP  Commercial

Insurance ID: Click or tap here to enter text. Insurance ID: Click or tap here to enter text.

Group # Click or tap here to enter text. Group # Click or tap here to enter text.

Subscriber: Click or tap here to enter text. Subscriber: Click or tap here to enter text.

Subscriber DOB: Click or tap here to enter text. Subscriber DOB: Click or tap here to enter text.

Please fax or email the completed referral and a Release of Information (ROI) to Sue at:

651-342-8020

Any questions, please contact Sue at 952-208-5198