





Name of referred person _		Birthdate Gender 🔘 🤇	
Address	City		
State	Zip Code	Phone	
Services you are seeking:	Adult Rehabilitative Mental Health Services Mental Health Targeted Case Management Children's Skills Training or Behavioral Aide Psychotherapy		O Diagnostic Assessment O Autism Evaluation/Intervention
Primary diagnosis (if known)			
Reason for referral			
Current living situation:	O Private Home/Apt. O Foster Care O Board & Lodge	O RTC	Homeless/ShelterJail/PrisonOther
Guardian (if any)			Phone
Case manager/agency (if a	ny)		Phone
Name & agencies of other Health/Behavioral Health pro			
Insurance/health care type	Medical Assistance MinnesotaCare VA	_	nercial
Insurance carrier (ie. Medica)	Insura	ince ID number
Requested start date			
Name person making requ	est		_ Phone
Relationship to referred pe	rson		_
How best to contact: (list whom to contact, days, hours times & phone numbers where it is best to reach them)	S,		
Signature		Date	
Call with questions: D	uluth & North Shore 218.7	/24.3122 Metro 612	.254.4179 Fax: 833.933.0639

Mail: 101 West 2nd Street, Duluth, MN 55802