**Stride Health Services, Inc.** Intake Date (office use only):\_\_\_\_\_\_\_\_\_

Tel: 612-333-0307 Fax: 612-333-0308

***ARMHS***

Adult Rehabilitative Mental Health Services Program

Referral For Service

\*Referral Form must be completed in full\*

***Referral Date:* \_\_\_\_\_\_\_\_\_\_\_**

**Personal Information**

Initial Diagnosis: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Is client aware of diagnosis? Axis I: Yes \_\_\_\_ No \_\_\_\_ Axis II: Yes \_\_\_\_ No \_\_\_\_

Is client currently under commitment?: Yes \_\_\_\_\_ No \_\_\_\_\_

Expiration date of commitment: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

What is the date of the most recent Diagnostic Assessment (DA): **\_\_\_\_\_\_\_\_\_\_\_\_\_**

*If available, please include a copy of the most recent Diagnostic Assessment (DA) with the referral.*

PMI Number/Subscriber ID (MA): \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Is the client on a PMAP(Prepaid Medical Assistance Plan): Yes \_\_\_\_ No \_\_\_\_ Unknown \_\_\_\_

*If the client is on a PMAP please fill out the information below if known*

PMAP Provider: **\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

PMAP ID Number: **\_\_\_\_\_\_\_\_\_\_\_\_\_** PMAP Group Number: **\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

|  |  |  |
| --- | --- | --- |
| First Name:  | M.I.: | Last Name: |
| Date of Birth: | Gender: [ ]  Male [ ]  Female[ ]  Prefer not to answer[ ]  Other: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | Race:  | SSN: |
| Address: | City:  | Zip code:  |
| Phone Number: | Cell Number:  | E-mail address: |

**Case Manager Information:**

|  |  |
| --- | --- |
| First Name:  | Last Name: |
| County/Agency: | Office Number:  | Cell Number: |
| Address: | City:  | Zip code:  |
| Email address: | Fax Number:  | Other: |

**Psychiatrist Information:**

|  |  |
| --- | --- |
| First name: | Last name: |
| Best Contact Number:  | Address:  |

**Other Service Providers:**

|  |  |
| --- | --- |
| Provider Name & Agency: | Best Contact Number: |
| Provider Name & Agency:  | Best Contact Number:  |
| Provider Name & Agency: | Best Contact Number: |

**Primary Emergency Contact Information**

|  |  |
| --- | --- |
| First name: | Last name: |
| Best Contact Number:  | Relationship:  |

**Special Needs**

|  |
| --- |
| Are there any known cultural consideration needs? [ ]  Yes [ ]  No specify: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Is there any gender preference regarding the assigned staff? [ ]  Yes [ ]  No If yes: [ ]  Male [ ]  Female [ ] No preferenceAllergies: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Other (be specific): \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |

**Legal Status & Legal Representative Contact Information** (if applicable)

|  |
| --- |
| [ ]  responsible for self [ ]  under guardianship *(complete section below)*[ ]  under commitment  |
| First name: | Last name: |
| Address: | City:  | Zip code: |
| Best Contact Number:  | Fax Number:  | Email: |

**Please complete the following tables below to the best of your knowledge**

|  |  |  |  |
| --- | --- | --- | --- |
| **Location** | **Total # of Admissions** | **Most Recent Admission**  | **Approximate Date** |
|   |   |   |   |
| **State Hospital/Regional Treatment Center** |   |   |   |
| **Inpatient Non-State Hospital** |   |   |   |
| **Residential Treatment** |   |   |   |
| **Outpatient Care** |   |   |   |
| **Day Treatment Involvement** |   |   |   |

|  |  |  |
| --- | --- | --- |
| **Check all that apply** | **Areas of Need** | **Please Describe Presenting Problem in identified Areas** |
|   |   |   |
|  | **COMMUNITY INTERVENTION** |  |
|  | **MEDICATION MONITORING EDUCATION** |  |
|  | **BENEFITS ASSISTANCE** |  |
|  | **INDEPENDENT LIVING SKILLS** |  |
|  | **SYMPTOMS MANAGEMENT** |  |
|  | **SELF-CARE** |  |
|  | **HOME MAINTENANCE** |  |
|  | **VOCATIONAL FUNCTIONING** |  |
|  | **SOCIAL FUNCTIONING** |  |
|  | **EDUCATIONAL FUNCTIONING** |  |
|  | **MEDICAL / DENTAL NEEDS** |  |

**DOES CLIENT KNOW OF THIS REFERRAL?** YES **🞐** NO **🞐**

**RELEASE OF INFORMATION:** Yes **🞐** No **🞐** (sent with form)

**REFERRAL SOURCE:** SELF-REFERRED **🞐** REFERENT INITIATED **🞐**

**HOW DID YOU HEAR ABOUT ARMHS?**

**\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Date Form Completed: \_\_\_\_\_\_\_\_\_\_**

**Referred By: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Phone: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

*The following for office use only:*

**Date Form Received: \_\_\_\_\_\_\_\_\_\_\_\_\_**

**Received By: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Date Contact Made: \_\_\_\_\_\_\_\_**

**Contacted By: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**