REFERRAL FORM:

**Beechwood, Inc ARMHS Services**

**REFERRAL SOURCE:**

|  |  |  |  |
| --- | --- | --- | --- |
| Name: |  | Date of Referral: |  |
| Agency: |  | Phone: |  |
| Email Address: |  | Fax: |  |

**CLIENT INFORMATION:**

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| Name: |  | | Birthdate: |  |
| Address: |  | | Phone (preferred): |  |
|  |  | | Phone (secondary): |  |
| Insurance Co.: |  | | MA/ PMI #: |  |
| Income Source/Amount: |  | | Does Client Have Spenddown? |  |
| Primary Physician: |  | | Phone/Clinic: |  |
| Psychiatrist: |  | | Phone/Clinic: |  |
| Therapist: |  | | Phone/Clinic: |  |
| Other Provider(s): |  | | Phone: |  |
| Other Provider(s): |  | | Phone: |  |
| Mental Health Diagnoses or Primary Symptoms (if known): | |  | | |
| Currently Suicidal?  If so, is safety plan in use? | |  | | |
| Currently Homicidal?  If so, is safety plan in use? | |  | | |
| Past ARMHS providers and when those services ended, if known: | |  | | |

**Check areas in which client needs help/ support:**

Basic Living Skills

Budgeting

Meal Planning/ Grocery Shopping

Obtaining and Maintaining Housing

Self-care

Vocational/ Educational

Transportation

Obtain/ Maintain Financial Assistance

Medical/ Dental Health

Children’s Needs

Social Functioning/ Leisure Time

Interpersonal Relationship Skills

Mental Health Symptom Management

Mental Health Service Needs

Medication Education

Chemical Health

|  |  |
| --- | --- |
| What are your (referrer’s) goals for the client in ARMHS: |  |
| What are client’s goals and motivations for ARMHS: |  |
| Any other relevant information not included in the form above that you would like to convey about this client: |  |

**\*\*\*Please attach any additional information that might assist in assessing this person’s needs such as previous Diagnostic Assessments, Psychological Test Results, Functional Assessments, Medical Opinion Forms, hospital discharge summaries, etc.\*\*\***

**Fax to: 612-825-0789 Attn: BeechWood ARMHS**