SANFORD HEALTH

Community Based Services

County: Pennington/Roseau/Clearwater/Lake of the Woods/Marshall

Request for Services/Referral Information

Referral for: **Adult: ☐ ARMHS ☐ CSP** **Children/Families: ☐ CTSS**

Demographic Information:

Name: _____ DOB: _____

Parent's names (if child): _____ Legal Guardian _____

Address: _____ Telephone: _____

Primary Diagnosis: _____

Diagnostic Assessment Completed: ☐ Yes - Date completed _____(please provide copy w/referral)

☐ No - when is it scheduled and with whom _____

Medical Provider: _____

Significant medical history _____

Psychiatrist and/or Psychologist _____

Psychiatric History (including hospitalizations)_____

_____

Current Medications: _____

Referral Information:

Date of Referral: _____ Referral Source: _____ Contact #_____

County of Residence/Financial Responsibility: _____ Case Manager (if applicable)_____

Employment Info/Income Source: _____

Insurance provider: ☐ MA ☐ PMAP ☐ Medicare ☐ Private ☐ None Name of Policy Holder:_____

Current Placement: ☐ Hospitalized ☐ Treatment Facility ☐ Foster Care/Group Home ☐ Correctional Facility

Current Legal Status/Social Service Involvement: ☐ Probation/Parole ☐ Commitment ☐ Provisional Discharge

☐ Child Welfare (vol) ☐ Child Protection ☐ Open CHIPS petition ☐ Guardian ad litem

Presenting Problems/Reason for Referral:

_____

_____

_____

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Assistance needed with: (check all that apply)

- ☐ Behavior Management
- ☐ Budgeting and Shopping
- ☐ Community Resource
- ☐ Coping Skills Utilization
- ☐ Cooking and Nutrition
- ☐ Coping Skills Training
- ☐ Crisis Assistance
- ☐ Educational Assistance
- ☐ Employment-related
- ☐ Family Skills Training
- ☐ Healthy Lifestyle Skills
- ☐ Household Management
- ☐ Housing Assistance
- ☐ Hygiene Issues
- ☐ Illness Management and Recovery
- ☐ Individual Skills Training
- ☐ Interpersonal Communication Skills
- ☐ Medication Education
- ☐ Medication Management
- ☐ Mental Illness Symptom Management
- ☐ Parenting Skills/Support
- ☐ Relapse Prevention
- ☐ Transition to Community Living
- ☐ Transportation Skills
- ☐ Other _____

Other considerations in providing services to individual/family (comfort with specific gender provider, cultural considerations, interests etc.)

_____

_____

_____

Please include the following with referral (if not provided may delay consideration for services):

- ☐ Current Diagnostic Assessment
- ☐ Individual Community Support Plan
- ☐ Commitment paperwork (if applicable)

Person filing out form _____ _____ _____

Date Time

For CBS Staff use only:

- ☐ Meets eligibility requirements
- ☐ Contacted patient/family on _____ and agreed to services
- ☐ Assigned to Primary Practitioner _____