ARMHS, Aftercare, and Therapy Referral Form

(ARMHS available in Clay County, Aftercare available in Clay and Wilkin County)

Referral Date: ___/___/_____

Referral Source (Name/Agency): _____ **Phone Number:** _____

Reason for Referral: _____

_____

_____

Client Name: _____ **Phone Number:** _____

SSN:_____ **Preferred Pronouns:**_____ **Previous Client:** Yes ☐ No ☐

MA#: _____ **DOB** ___/___/_____ **MCO:** _____

Client Address:_____ **City:**_____ **Zip:** _____

Guardian Name: _____ **Phone Number:** _____
(If Applicable)

MH Diagnosis: _____

Most Recent Diagnostic Assessment Date: ___/___/_____ **Agency:** _____
(Please include ROI for agency/provider who completed most recent D.A.)

Other Services/Providers Involved: _____

_____

Current Living Situation: ☐ Independent ☐ Treatment Center ☐ Shelter ☐ Other

*****Aftercare Referrals Only:** (Please indicate at least one criteria for which the client meets)

- ☐ Recent psychiatric hospitalization
- ☐ Multiple psychiatric hospitalizations
- ☐ High risk for psychiatric hospitalization due to increased or acute symptoms
- ☐ Recently screened for or currently on civil commitment
- ☐ Transitioning from CBHH, IRTS or CSU
- ☐ High level of medical co-morbidity, not currently being addressed by inpatient or home health providers

Risk Factor: Client ***has had*** aggressive behavior preceding or during hospitalization

☐ **Yes** ☐ **No**

CCRI Office use only:

Date MNITS Verified ___/___/_____ Appt. Scheduled: ___/___/_____
Letter sent: ☐ Entered in Excel: ☐ Interpreter: ☐
Notes: