VILLAGE WELLNESS CENTER

1350 Energy Lane Suite 109, St. Paul, MN 55108 | Phone| 651-269-2760 | Fax| 651-340-6107 | email: info.vwc19@gmail.com

REFERRAL FOR SERVICES

(Please fax/email the Client's signed ROI, their most recent diagnostic assessment, any other relevant paperwork for client)

Referral Source Information:

Name:	**Phone Number:**
Agency:	**Email:**

Client Information:

NAME: ____MALE: _______ FEMALE: _______

Preferred Name: _____________________ Date of Birth:_________________ Social Security#:______________________

PRESENT ADDRESS____

HOME PHONE:___________________________________CELLPHONE: _______________________________________

PSYCHIATRIST: ____ PHONE: ___________________________________

OTHER SERVICE PROVIDERS: ____

Is client currently under commitment? YES____NO____ Expiration Date: ______________________ Race____________

INSURANCE SOURCE: (need numbers here)

ID#: ________________________________ GROUP#: ________________________ PMAP#: _______________________

INITIAL DIAGNOSIS (IF ANY): ____

Is client aware of diagnosis? YES____NO____

PLEASE ATTACH THE MOST RECENT DIAGNOSTIC ASSESSMENT WITH THIS FORM IF THERE IS ONE

(Circle one): DA attached DA not available DA need

DA must have been done within the last 180 days and must indicate need for ARMHS should these services be requested.

Additional Information:

Reason for referral?
Has the client received ARMHS service from other agency with in the last year? _____Yes ________ NO
Are there any emergency contacts for the Client? If yes, please list a name, relationship to the client, and their phone number below? _______ Yes ______ No:

DOES CLIENT KNOW OF THIS REFERRAL? YES____NO____ **RELEASE OF INFORMATION:** COMPLETED____