



**ARMHS SERVICES REFERRAL FORM**

Person/Agency of referral source: \_\_\_\_\_  
Phone number of referral source: \_\_\_\_\_ Date referred: \_\_\_\_\_

**Demographic Information**

Client's Full Legal Name: \_\_\_\_\_ Maiden Name: \_\_\_\_\_

Alias: \_\_\_\_\_ Sex:  M  F  Other Home Phone: \_\_\_\_\_

Address: \_\_\_\_\_

County of Financial Responsibility: \_\_\_\_\_ County of Residence: \_\_\_\_\_

DOB: \_\_\_\_\_ Social Security: \_\_\_\_\_ PMI#: \_\_\_\_\_

Medical Insurance (Name/ID#): \_\_\_\_\_

Race:  Am. Indian  Asian  African Am.  Hispanic  White/Caucasian  
 Other (Please specify) \_\_\_\_\_

Primary Language: \_\_\_\_\_ U.S. Citizen:  Yes  No

Marital Status:  Never Married  Married  Divorced  Widowed  Separated  Cohabiting

Financial:  Social Security  Social Security Insurance (SSI)  Veteran Benefits

Other financial resources (please specify)? \_\_\_\_\_

Rep Payee:  Yes  No If yes, who? \_\_\_\_\_

Employment Status:  Homemaker  Disabled  FT Employee  PT Employee  
 Seasonal  Student  Laid Off  Sheltered Employment  Retired  
 Unemployed  Unknown  Other (Please Specify) \_\_\_\_\_

Client's Living Arrangements:  No permanent address  Own home  Apartment  
 Board and Lodge  Family foster home  Intensive Residential Treatment  
 Home of immediate family  Home of extended family

Physical Disabilities:  None  Semi-ambulatory  Non-ambulatory  Hearing impaired  
 Deaf  Blind  Other

Does the client have a legal Guardian?  Yes  No If yes, who? \_\_\_\_\_

Does the client have an Advance Directive?  Yes  No

Legal Status (select all that apply):  Probation  Stay of Commitment  MI Commitment  
 CD Commitment  MI/CD Commitment  MI&D If yes, please indicate the start and  
end of legal status: \_\_\_\_\_

Diagnosis:  
Axis I: \_\_\_\_\_  
Axis II: \_\_\_\_\_  
Axis III: \_\_\_\_\_

Current stressors/losses/conflicts: \_\_\_\_\_  
\_\_\_\_\_

Current medications (dose/frequency and allergies): \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

### Formal Supports

Case Manager: \_\_\_\_\_ Phone: \_\_\_\_\_  
Financial Worker: \_\_\_\_\_ Phone: \_\_\_\_\_  
Psychiatrist: \_\_\_\_\_ Phone: \_\_\_\_\_  
Therapist: \_\_\_\_\_ Phone: \_\_\_\_\_  
Medical Doctor: \_\_\_\_\_ Phone: \_\_\_\_\_  
Probation Officer: \_\_\_\_\_ Phone: \_\_\_\_\_  
Community Services/Treatment groups (please specify where and phone number of the agency providing services):  
\_\_\_\_\_  
Other: \_\_\_\_\_ Phone: \_\_\_\_\_  
Other: \_\_\_\_\_ Phone: \_\_\_\_\_

### Client Treatment History

**Most recent hospitalization or treatment (Please specify hospital, physical or counselor) for:**

Physical Health: \_\_\_\_\_

Mental Health: \_\_\_\_\_

Chemical Health (please specify drug of choice): \_\_\_\_\_

### Behavioral History

**Legal issues not previously noted:** \_\_\_\_\_

**Suicidal ideation:** \_\_\_\_\_ Plan \_\_\_\_\_ Threats \_\_\_\_\_ Current \_\_\_\_\_ Past \_\_\_\_\_

Comments: \_\_\_\_\_

**Self-Injurious Behavior:** \_\_\_\_\_ Plan \_\_\_\_\_ Threats \_\_\_\_\_ Current \_\_\_\_\_ Past \_\_\_\_\_

Comments: \_\_\_\_\_

**Homicidal ideation:** \_\_\_\_\_ Plan \_\_\_\_\_ Threats \_\_\_\_\_ Current \_\_\_\_\_ Past \_\_\_\_\_

Comments: \_\_\_\_\_

**Aggression (Verbal/physical):** \_\_\_\_\_ Plan \_\_\_\_\_ Threats \_\_\_\_\_ Current \_\_\_\_\_ Past \_\_\_\_\_

Comments: \_\_\_\_\_

**Access to weapons:** \_\_\_\_\_ Plan \_\_\_\_\_ Threats \_\_\_\_\_ Current \_\_\_\_\_ Past \_\_\_\_\_

Comments: \_\_\_\_\_

**Client strengths:** \_\_\_\_\_

**Client needs:** \_\_\_\_\_

**Informal supports** (such as significant other, children friends, church, social clubs): \_\_\_\_\_

**The services and skills the client needs to work on are:** (Please check all that apply):

- |   |   |
|---|---|
| <input type="checkbox"/> Interpersonal communication skills                                 | <input type="checkbox"/> Health Care Directives                 |
| <input type="checkbox"/> Community resource utilization and integration skills              | <input type="checkbox"/> Household management skills            |
| <input type="checkbox"/> Crisis assistance/development of a crisis plan                     | <input type="checkbox"/> Cooking and nutrition                  |
| <input type="checkbox"/> Budgeting and shopping skills                                      | <input type="checkbox"/> Transportation skills                  |
| <input type="checkbox"/> Medication monitoring  | <input type="checkbox"/> Healthy lifestyle skills and practices |
| <input type="checkbox"/> Mental illness symptom management skills                           | <input type="checkbox"/> Pre-employment skills                  |
| <input type="checkbox"/> Relapse prevention   |   |
| <input type="checkbox"/> Community intervention (to reduce barriers to employment/housing). |   |
| <input type="checkbox"/> Medication education   |   |

**Other goals not listed or would like to expand on:** \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

**How often would you like the client to be seen** (check one)? \_\_\_\_\_ 2x Weekly \_\_\_\_\_ 1x Weekly  
\_\_\_\_\_ Bi-monthly \_\_\_\_\_ Monthly \_\_\_\_\_ Other \_\_\_\_\_

**Please submit the following documents with the client referral form (if available):**

- Current Diagnostic Assessment
- Current Functional Assessment
- Current psychiatric, chemical health and medical records
- Advance Directive (or the location this document could be found)
- Case Manager's Individual Treatment Plan

**Please submit the referral form and attachments to:**

Safe Transitions  
Attn: Alison Stowell  
1501 Highway 33 S  
Cloquet, MN 55720  
Secure Fax: (218) 8782029  
Phone: (218) 878-1364

**If you have any questions about this process, please call (218) 878-1364**

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**For Safe Transitions Purposes Only**

Date referral was received: \_\_\_\_\_ Date client was assigned: \_\_\_\_\_

ARMHS worker assigned: \_\_\_\_\_

Initial client contact date (face to face): \_\_\_\_\_