# SAFE TRANSITIONS, INC.

## ARMHS REFERRAL FORM

**Person/Agency of referral source:** _____
**Phone number of referral source:** _____ **Date referred**: _____

## Client Information

**Client's Full Legal Name:** _____ **Maiden Name:** _____
**Alias:** _____ **Sex**: ___M ___ F ___ Other **Home Phone**: _____
**D.O.B**_____ **Social Security #:**_____
**Address**: _____
**Medical Insurance (Name/ID#):**_____
**Diagnosis:** _____

**Name Guardian/Legal Representative(if applicable):**_____**Phone number:**_____

An updated and completed Diagnostic Assessment is needed, please include with this referral form, if possible. ARMHS services cannot start until the Diagnostic Assessment is complete. We can help you with getting a Diagnostic Assessment if you need help.

**Comments:**

_____
_____
_____
_____
_____
_____
_____
_____
_____

**Any additional information you would like us to have please fax to the Barnum office with attn.: Missie L./ARMHS on it. Thank you!**

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

Safe Transitions, Inc.
Attn: Missie LaChappelle
1501 Highway 33 South Cloquet, MN 55720
Cloquet Fax: (218) 878-2029
Cloquet Phone: (218) 878-1364
Or
3656 Front Street Barnum, MN 55707
Barnum Fax: (218) 389-9851

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