



COMUNIDADES LATINAS  
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Date of Referral:

## Children's Mental Health Case Management Referral Form

Client Name:	Date of Birth:
Parent/Guardian Name(s):	
Address:	
Phone number:	

Referral Source:	Relationship to Client:
Agency/School/Clinic:	
Address:	
Phone number:	Fax Number:

Insurance Company:
Primary Policy Holder:
Group Number:
Policy/ ID Number:



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Reason for referral and description of how case management services can help this client develop better mental health:

What services (mental health, educational, healthcare, etc.) are already in place, including provider(s)?

Additional information to support this referral (engagement tips, family system functioning, significant history, etc.):

**Release of information included?**

**\*\*Please note that external referrals will not be accepted without a release of information.**

**SED Status Documented in DA**

**SED Status Documented Below**

**For external referrals, please send referral documents to:**

**[mhintake@clues.org](mailto:mhintake@clues.org) (preferred – please remember to encrypt your message)**



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or Fax: (612) 871-1058, Attn: MH Intake

**SED Documentation to accompany Diagnostic Assessment:**

Diagnostic Assessment was completed by \_\_\_\_\_ (provider)

on \_\_\_\_\_ (date) for \_\_\_\_\_ (client).

This client meets eligibility criteria for a Severe Emotional Disturbance.

Serious Emotional Disturbance (SED) means the condition of child who has a mental health diagnosis AND meets at least one of the following criteria (check all that apply):

- The child has been admitted within the last three years or is at risk of being admitted to inpatient treatment or residential treatment for an emotional disturbance; OR
- The child is a Minnesota resident, and is receiving inpatient treatment or residential treatment for an emotional disturbance through the interstate compact; OR
- The child has one of the following as determined by a mental health professional:
  - Psychosis or clinical depression; OR
  - Risk of harming self or others as a result of an emotional disturbance; OR
  - Psychopathological symptoms as a result of being a victim of physical or sexual abuse or of psychic trauma within the past year; OR
  - The child, as a result of an emotional disturbance, has significantly impaired home, school or community functioning that has lasted at least one year OR in the written opinion of a mental health professional presents a substantial risk of lasting at least one year.

\_\_\_\_\_  
Provider Signature (with credentials)

\_\_\_\_\_  
Date

\_\_\_\_\_  
Supervisor Signature (unlicensed staff only)

\_\_\_\_\_  
Date



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