ARMHS External Referral Form

General Information

Client Name: ____ Date of Birth: ____________________

Pronouns: _______________________ Does Client have a Legal Guardian: Yes | No

Name of Legal Guardian: _________________________ Phone Number: (   ) ______________

Good Time to return call: AM | PM Consent to leave a voicemail: Yes | No

A resident of Hennepin County or Ramsey County?

At this time, CLUES can only serve residents of Hennepin & Ramsey Counties.

Address: ____

Source of Referral

Referral Source: ___________________________________ Relationship to Client: ________________

Agency: ____ Phone Number: ____________________

Email: _______________________________________

Release of information Attached: O Yes O No

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

Please encrypt the email and send the referral form and release(s) of information to:

Email: mhintake@clues.org

Existing Services

Is the client currently receiving therapy: O Yes O No [If yes; please include most recent Diagnostic Assessment]

Name of Therapist: ______________________________________ Email: ________________________

Agency Name: _________________________________ Phone Number: _____________________

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797 East Seventh Street
Saint Paul, MN 55106
Tel: (651) 379-4200
Fax: (651) 292-0347

2600 East 25th Street
Minneapolis MN 55406

Insurance Information

Insurance Company: ______________________________

Primary Policy Holder: ______________________________

Group Number: ______________ Policy/ID Number: ______________

What functional difficulties will ARMHS services address?

- ☐ Mental health symptoms
- ☐ Mental health service participation
- ☐ Substance use
- ☐ Other
- ☐ Vocational and educational
- ☐ Social functioning
- ☐ Interpersonal functioning
- ☐ Self-care and living independently
- ☐ Medical and dental health
- ☐ Financial assistance
- ☐ Housing and transportation

Please indicate which areas of difficulties this individual experiences and briefly describe. Clients need to experience significant difficulties in at **least three** areas to qualify for ARMHS.

1. ______________________________

2. ______________________________

3. ______________________________

Necessity of Care Recommendation or Referral

☐ Included in the Diagnostic Assessment ☐ Attached below as an addendum

ARMHS Necessity Care Process

I, ______________, attest ______________ that needs ARMHS to help bring restorative, recovery-oriented interventions directly to them, whether in their homes or elsewhere in the community. ARMHS includes four components: basic living and social skills, community intervention, medication education, and transitioning to community living. They would benefit from the following service components: ______________

This client would benefit from these services because ______________

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