Adolescent Mental Health/Substance Mis Use Referral Form

Please attach the required ROI's/Diagnostic/Psychiatric/Psychological Assessment that is dated within the last 6 months to this referral form.

Fax to 612.887.1430 or email to MHIntake@clues.org
(Please do not let lack of permission be a barrier to referring)

Referral Date: _____

Referent's Information

Name	Agency	Phone	Fax
Email Address			

Child Information

Name	Preferred Name	Preferred Pronouns
Gender	**Race**	**Ethnicity**
DOB	**Current Residence**	

Have you discussed this referral with the child? ☐ Yes ☐ No

Parent/Guardian Information

Name	Relation to Child	Phone	Address	Email

Have you discussed this referral with the child's parent/guardian? ☐ Yes ☐ No

Languages Regularly Spoken

Insurance Information

Insurance Company	ID Number	Group Number	Policy Holder
			Policy Holder DOB

Educational Information

School Name	District	Grade	School Contact Person

Does this child have an Individual Education Plan? ☐ Yes ☐ No

Current Providers	*Name/Agency*	*Phone*	*Email/Fax*
Individual Therapist			
Family Therapist			
Psychiatrist			
Skills Worker			
Day Treatment			
Probation Officer			
County Worker			
Other			

Is the teen open to or working with other Services? (i.e. Social Worker, Outside Support Groups,etc)
Yes ☐ **No** ☐

Has the teen/parent/carer given permission for CLUES to work with them/their child: Yes ☐ **No** ☐

Reason for Referral: