

**Mental Health Services Request**

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| **NAME:**  | page1image2924016**REFERRAL DATE:**  |
| **DOB:**  | **SSN #: (optional)** | page1image3771312page1image3772144**GENDER:** page1image3772768page1image3773184 | page1image3773600**ETHNICITY:** page1image3774224page1image3774640 |
| **ADDRESS:**  | **COUNTY:** page1image3775472page1image3775888 |
| **PHONE:**  | page1image3777968**EMAIL:** page1image3778592 | **PRIMARY LANGUAGE: INTERPRETER: YES NO** page1image3779424 |
| **INSURANCE PROVIDER: Subscriber ID #:Group #:**  | **MA #:PMAP: Yes No (please circle)** page1image3781088 |
| **REFERRING SOURCE NAME/AGENCY:** **REFERRING SOURCE PHONE/ EMAIL/ADDRESS:**  |
| **Biological parent or guardian’s Name/ Address/Phone # (if the client is a minor):**  | page1image3784416page1image3784832**Are you comfortable being seen by an unlicensed intern?** Yes No page1image3785456page1image3785872 |
| **AREAS OF NEED/TREATMENT GOALS:**  |
| page1image1696416**If available, please include the following records:** ☐ **Diagnostic Assessment (**most recent**)** ☐ **Crisis Plan** ☐ **Rule 25** ☐ **Discharge Summary** ☐ **Functional Assessment** ☐ **IEP** ☐ **Any other supporting documents**  |

**Please either fax or send referrals via secure email:**

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