

Community Based Services

County: Pennington/Roseau/Clearwater/Lake of the Woods/Marshall

**Request for Services/Referral
Information**

Referral for: **Adult:** ARMHS CSP

Children/Families: CTSS

Demographic Information:

Name: _____ DOB: _____

Parent's names (if child): _____ Legal Guardian _____

Address: _____ Telephone: _____

Primary Diagnosis: _____

Diagnostic Assessment Completed: Yes - Date completed _____ (please provide copy w/referral)

No - when is it scheduled and with whom _____

Medical Provider: _____

Significant medical history _____

Psychiatrist and/or Psychologist _____

Psychiatric History (including hospitalizations) _____

Current Medications: _____

Referral Information:

Date of Referral: _____ Referral Source: _____ Contact # _____

County of Residence/Financial Responsibility: _____ Case Manager (if applicable) _____

Employment Info/Income Source: _____

Insurance provider: MA PMAP Medicare Private None Name of Policy Holder: _____

Current Placement: Hospitalized Treatment Facility Foster Care/Group Home Correctional Facility

Current Legal Status/Social Service Involvement: Probation/Parole Commitment Provisional Discharge

Child Welfare (vol) Child Protection Open CHIPS petition Guardian ad litem

Presenting Problems/Reason for Referral:



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Assistance needed with: (check all that apply)

- | | | |
|--|--|---|
| <input type="checkbox"/> Behavior Management | <input type="checkbox"/> Employment-related | <input type="checkbox"/> Interpersonal Communication Skills |
| <input type="checkbox"/> Budgeting and Shopping | <input type="checkbox"/> Family Skills Training | <input type="checkbox"/> Medication Education |
| <input type="checkbox"/> Community Resource | <input type="checkbox"/> Healthy Lifestyle Skills | <input type="checkbox"/> Medication Management |
| <input type="checkbox"/> Coping Skills Utilization | <input type="checkbox"/> Household Management | <input type="checkbox"/> Mental Illness Symptom Management |
| <input type="checkbox"/> Cooking and Nutrition | <input type="checkbox"/> Housing Assistance | <input type="checkbox"/> Parenting Skills/Support |
| <input type="checkbox"/> Coping Skills Training | <input type="checkbox"/> Hygiene Issues | <input type="checkbox"/> Relapse Prevention |
| <input type="checkbox"/> Crisis Assistance | <input type="checkbox"/> Illness Management and Recovery | <input type="checkbox"/> Transition to Community Living |
| <input type="checkbox"/> Educational Assistance | <input type="checkbox"/> Individual Skills Training | <input type="checkbox"/> Transportation Skills |
| <input type="checkbox"/> Other _____ | | |

Other considerations in providing services to individual/family (comfort with specific gender provider, cultural considerations, interests etc.)

Please include the following with referral (if not provided may delay consideration for services):

- Current Diagnostic Assessment
- Individual Community Support Plan
- Commitment paperwork (if applicable)

Person filing out form _____ Date _____ Time _____

<p>For CBS Staff use only:</p> <p><input type="checkbox"/> Meets eligibility requirements</p> <p><input type="checkbox"/> Contacted patient/family on _____ and agreed to services</p> <p><input type="checkbox"/> Assigned to Primary Practitioner _____</p>
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