Sanford Health Behavioral Health Center

Bemidji
722 15th St. NW
Bemidji, MN 56601
(218) 333-2200 (office)
(218) 751-3298 (fax)

Bemidji
1705 Anne Street NW
Bemidji, MN 56601
(218) 333-2035 (office)
(218) 444-3212 (fax)

Bemidji
1611 Anne Street NW
Bemidji, MN 56601
(218) 333-2105 (office)
(218) 333-2110 (fax)

Headwaters ACT
116 3rd Street NW
Bemidji, MN 56601
(218) 333-2220 (office)
(218) 444-5491 (fax)

SANFORD
Behavioral Health Center

Headwaters ACT Referral Form

Date of Referral:_____

Recipient Name:_____ Date of Birth:_____

Primary Address:_____ County of Residence:_____

Phone:_____ County of Financial Responsibility_____

Social Security #: _____

Primary Insurance:_____ Insurance #:_____

Secondary Insurance:_____ Insurance #:_____

Referral Source:_____ Referent's Phone Number:_____

Referent's Email:_____

Reason for Referral:

_____

_____

_____

Is the client aware and in support of this referral? ☐ **Yes** ☐ **No**

Diagnosis *(If known)*

(Qualifying diagnoses: Bipolar I and II Disorder, Schizophrenia and Schizoaffective Disorders)

Most recent diagnostic assessment date:_____ Completed By:_____

DSM 5:_____

DSM 5:_____

DSM 5:_____

Past and Present Service Providers/Involved Persons *(If Known)*

(Please provide whom the client has worked with in the past 5 years.)

As a requirement of ACT services all psychiatric care services including psychiatry and counseling/therapy must be provided by the ACT team. Potential referrals should be aware that they would have to switch from their current providers to be in the ACT programming.

Psychiatrist:_____ Clinic:_____ Phone:_____

Is psychiatrist aware of this referral? ☐ Yes ☐ No In support of referral? ☐ Yes ☐ No

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Therapist:_____ Clinic:_____ Phone:_____
Is therapist aware of this referral? ☐ Yes ☐ No In support of referral? ☐ Yes ☐ No

County Social Worker:_____ Agency:_____ Phone:_____
Is county social worker aware of this referral? ☐ Yes ☐ No In support of referral? ☐ Yes ☐ No

Is the Recipient under a civil commitment? ☐ Yes ☐ No Type _____ Expiration Date: _____

ARMHS Worker:_____ Agency:_____ Phone:_____

Guardian/Conservator:_____ Phone:_____

Probation/DOC:_____ Phone:_____

Other:_____ Phone:_____

Other:_____ Phone:_____

Medical Information

Primary Doctor:_____ Clinic:_____ Phone:_____

Current Medications:

_____

_____

Pharmacy:_____

Is the recipient interested in Native American traditional healing or ceremony? ☐ Yes ☐ No

Referral Process

This referral form and any supporting documentation can be sent via the following ways:

- Office: (218) 333-2220
- Fax: (218) 444-5491
- Address: 116 3rd Street NW, Bemidji, MN 56601

Once referral information is received, ACT will be in contact with you to further discuss our program and the recipient's eligibility to the program. ACT will schedule an initial screening with the individual to explain the program and gather releases. At that point we gather as much current and past clinical information to review. If the individual appears to be a good fit for the program after the review, a Diagnostic Assessment will be scheduled, then an admissions meeting within the team takes place to make a decision on admission.

If a referral is not a good fit for the ACT program they will be provided with referrals to other community based services. If you have other questions regarding our programs, please do not hesitate to contact the office at (218) 333-2220. Thank you for your referral.