ABSOLUTE
HEALTH AND WELLNESS

ADULT REHABILITATIVE MENTAL HEALTH SERVICES (ARMHS)
REFERRAL FORM

Return completed form to us at **referral@ahwmn.com** (preferred) or **651-760-3884** (fax)

DATE OF REFERRAL: _____ REFERRED BY/RELATIONSHIP: _____

AGENCY & ADDRESS: _____

PHONE: _____ FAX: _____ EMAIL: _____

CLIENT GENERAL INFORMATION

NAME: _____ DOB: _____ SSN: _____ MA/PMI: _____

ADDRESS: _____ CITY/STATE/ZIP: _____

PHONE: _____ GENDER: ☐ MALE ☐ FEMALE ☐ OTHER

RACE/ETHNICITY: ☐ AFRICAN AMERICAN/BLACK ☐ ASIAN ☐ CAUCASIAN/WHITE ☐ LATINO/A ☐ AMERICAN INDIAN/ALASKA NATIVE ☐ NATIVE HAWAIIAN/PACIFIC ISLANDER

IS THIS INDIVIDUAL HIS/HER OWN GUARDIAN?

☐ YES ☐ NO: _____

IS THIS INDIVDIUAL AWARE OF THIS REFERRAL? ☐ NO ☐ YES

DAY TREATMENT OR WORK SCHEDULE? ☐ NO ☐ YES: _____

OTHER SERVICES RECEIVING:

☐ CASE MANAGEMENT: _____

☐ ILS/WAIVERED SERVICES: _____

☐ SUPPORTED EMPLOYMENT _____

IS THIS INDIVIDUAL OPEN TO TELEHEALTH SERVICES? ☐ YES ☐ NO

DOES THIS INDIVIDUAL HAVE A STAFF PREFERENCE? ☐ MALE ☐ FEMALE ☐ NO PREFERENCE

MENTAL HEALTH INFORMATION

MENTAL HEALTH DIAGNOSIS(ES): ☐ MAJOR DEPRESSION ☐ BIPOLAR DISORDER ☐ BORDERLINE PERSONALITY DISORDER ☐ SCHIZOPHRENIA ☐ SCHIZOAFFECTIVE DISORDER ☐ OTHER: _____

COGNITIVE IMPAIRMENT: ☐ BORDERLINE IQ ☐ MILD MR ☐ LEARNING DISABILITY

PSYCHIATRIST & CLINIC: _____ PHONE: _____

ADDRESS: _____ FAX: _____

THERAPIST & CLINIC: _____ PHONE: _____

ADDRESS: _____ FAX: _____

DO YOU HAVE MENTAL HEALTH RECORDS FOR THIS INDIVIDUAL? ☐ NO ☐ YES (PLEASE ATTACH)

NOTE: Diagnostic Assessment completed within one year of ARMHS intake must be obtained. Attachment of this document can expedite service start date.

ARMHS GOALS FOR THIS INDIVIDUAL/ REASON FOR REFERRAL:	
ADDITIONAL NOTES:	