FAMILY SUPPORT SERVICES, INC.
ADULT REHABILITATIVE MENTAL HEALTH SERVICES DIVISION
TEL: 952-746-2522 FAX: 952-746-0887

Intake Date:	_____
Time:	_____
County:	_____
Assigned Staff:	_____

REFERRAL FOR SERVICE

NAME:_____MALE:_____FEMALE:_____
PRESENT ADDRESS_____CITY:_____STATE:_____ZIP:_____
SOCIAL SECURITY #:_____DATE OF BIRTH:_____PHONE:_____
COUNTY CASE MANAGER:_____ADDRESS/PHONE:_____
PSYCHIATRIST:_____ ADDRESS/PHONE:_____
OTHER SERVICE PROVIDERS:_____
Is client currently under commitment? YES____NO____ Expiration Date:_____ Race_____

INCOME SOURCE: (need numbers here)

MA # :_____ PMAP #:_____ TPL #:_____

INITIAL DIAGNOSIS:_____

Is client aware of diagnosis? Axis I: YES____NO____ Axis II: YES____NO____

PLEASE ATTACH THE MOST RECENT DIAGNOSTIC ASSESSMENT WITH THIS FORM
(circle one): DA attached DA not available DA not done ** Date DA scheduled:**_____

DA must have been done within the last 180 days and must indicate need for ARMHS should these services be requested.

	TOTAL # OF ADMISSIONS	MOST RECENT ADMISSION	APPROPRIATE DATES OF SERVICE
STATE HOSPITAL/REGIONAL TREATMENT CENTER	_____	_____	_____
INPATIENT NON STATE HOSPITAL	_____	_____	_____
RESIDENTIAL TREATMENT	_____	_____	_____
OUTPATIENT CARE	_____	_____	_____
DAY TREATMENT INVOLVEMENT	_____	_____	_____

	AREAS OF NEED (check all that apply)	**PLEASE DESCRIBE PRESENTING PROBLEM IN IDENTIFIED AREAS**
	COMMUNITY INTERVENTION	
	MEDICATION MONITORING / EDUCATION	
	BENEFITS ASSISTANCE	
	INDEPENDENT LIVING SKILLS	
	SYMPTOMS MANAGEMENT	
	PSYCHO-SOCIAL REHAB	
	SELF-CARE	
	HOME MAINTENANCE	
	VOCATIONAL FUNCTIONING	
	SOCIAL FUNCTIONING	
	EDUCATIONAL FUNCTIONING	
	MEDICAL / DENTAL NEEDS	

DOES CLIENT KNOW OF THIS REFERRAL? YES____NO____ **RELEASE OF INFORMATION**: COMPLETED_____ **(sent with form)**

REFERRAL SOURCE: SELF-REFERRED:_____ REFERENT INITIATED:_____

HOW DID YOU HEAR ABOUT ARMHS? _____ **Name of ARMHS STAFF intended to provide services:** _____

DATE FORM COMPLETED:_____ REFERRED BY:_____PHONE:_____

DATE FORM RECEIVED:_____ RECEIVED BY:_____

DATE CONTACT MADE:_____ CONTACTED BY:_____