Hayden Health ARMHS Referral Form

Please complete the requested PDF form and email it to
haydenhealthresc@gmail.com - or call us at (612) 423-4038

REFERRAL INFO

DATE OF REFERRAL: _____ REFERRED BY/RELATIONSHIP: _____

AGENCY & ADDRESS: _____

PHONE: _____ FAX: _____ EMAIL: _____

CLIENT INFORMATION

NAME: _____ DOB: _____ PMI: _____ F-Code: _____

ADDRESS: _____ CITY/STATE/ZIP: _____

PHONE: _____ EMAIL: _____ GENDER: _____ RACE/ETHNICITY: _____

GUARDIAN: ☐ NO ☐ YES: _____
FIRST LAST PHONE EMAIL

1) Are you currently receiving ARMHS: ☐ NO ☐ YES: _____
2) Are you currently enrolled in an SUD program: ☐ NO ☐ YES: _____
3) Are you currently referring to other ARMHS Providers: ☐ NO ☐ YES: _____
4) Are you currently residing in a sober house, Crisis Home, or Hospital: ☐ NO ☐ YES: _____
5) Are you on a Civil Commitment: ☐ NO ☐ YES: _____
6) What areas do you need support in (Goals): _____
7) Do they have a Staff preference: ☐ MALE ☐ FEMALE ☐ NO PREFERENCE
   - How many hours a week: _____
   - Preferred Days/Times to meet: _____ ☐ Business Hrs ☐ Non-Business Hrs

MENTAL HEALTH INFORMATION

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

(Please attach a Release of Information for the following)

PSYCHIATRIST & CLINIC: _____ PHONE: _____

ADDRESS: _____ FAX: _____

THERAPIST & CLINIC: _____ PHONE: _____

ADDRESS: _____ FAX: _____

CLINICAL DOCUMENTS

THE FOLLOWING MUST BE SELECTED TO COMPLETE THE REFERRAL

Please select yes or no:

1. Does the individual have a current DA within 12 months? ☐ YES ☐ NO

   *If **Yes**- please include the Diagnostic Assessment with the referral form*

   *If **No**- please indicate availability to schedule a Diagnostic Assessment with Hayden's Clinician:*

   Preferred Days: ☐ Monday ☐ Tuesday ☐ Wednesday ☐ Thursday ☐ Friday

   Preferred Times: Contact client directly to schedule