Minnesota CarePartner
ROOTS RECOVERY

REFERRAL FORM - ADOLESCENT

This referral is for: ☐ Rule 25/Comp Assessment ☐ SUD IOP Treatment ☐ RootsREACH

Referent Information:

First Name:		**Last Name:**	
Company:		**Email:**	
Phone:		**Fax:**	
Relationship to the Client			

Client Information:

First Name:		**Middle:**		**Last Name:**	
Date of Birth:		**Social Security #**			
Reside on Reservation?	☐ Yes ☐ No Which:	**Eligible for Indian Health Services?**	☐ Yes ☐ No		
Race:		**Ethnicity:**		**Hispanic/Latino?**	☐ Yes ☐ No
Gender Identity:		**Preferred Pronouns:**			
Sexual Orientation:		**Living Situation:**			
Address:		**City**		**State**	**Zip**
Relationship Status:	☐ Single ☐ Married ☐ Separated ☐ Divorced ☐ Married ☐ Widowed ☐ Partnered				
Employment Status:	☐ Full-Time ☐ Part-Time ☐ Not Employed ☐ Self-Employed ☐ Retired ☐ Active Military ☐ Disabled				
Primary Phone:		**Message ok?**	☐ Yes ☐ No	**Email address:**	
Secondary Phone:		**Message ok?**	☐ Yes ☐ No		
Preferred Method of Contact:	☐ Phone Call ☐ Text ☐ Email	**Best Time to Contact:**			
Currently Receiving Methadone/Suboxone?	☐ Yes ☐ No	**Clinic?:**			
Please list any medications you're currently prescribed, and indicate who prescribes them:					
Medication List: *Include dosage*				**Prescribed by:**	
Mental Health Diagnoses/Concerns:					
Current Mental Health Therapy/Psychiatry:					
Please indicate if you have any of the following contacts/relationships: *Please have contact details ready for releases of information*	☐ Probation/Parole ☐ Child Protection ☐ Case Manager ☐ Psychotherapy ☐ Psychiatry ☐ Primary Doctor ☐ Specialty Doctor ☐ Drug/DUI Court ☐ Civil Commitment ☐ Sex-Offender Registration ☐ CTSS/ARMHS/ILS Worker ☐ Public Defender				

Funding/Payment Information:

What is the planned payment method for services?	☐ Self-Pay ☐ Insurance ☐ Other:				
Client Insurance?	☐ Yes ☐ No	**Type:**	☐ Commercial ☐ PMAP ☐ MA/Medicaid	**PMI #:**	
Insurance Carrier:	☐ Ucare ☐ Medicaid/MA/PMAP ☐ Preferred One ☐ Hennepin Health ☐ Medica ☐ Health Partners ☐ BlueCross ☐ Other				
Policy Holder:	☐ Client ☐ Parent/Guardian ☐ Spouse/Other	**Name:**			
Policy Number:		**Group Number:**		**Prior Auth Needed?**	☐ Yes ☐ No

School & Guardian Information:

Are you currently attending school	☐ Yes ☐ No	If so, what school?	
What is your schedule?		Are you behind in credits?	☐ Yes ☐ No
Are you attending consistently?	☐ Yes ☐ No	Are you truant?	☐ Yes ☐ No
Who is/are your legal guardian(s)?			

Emergency Contact Information:

Who should we use as an emergency contact?			
What is their relationship to you?		Phone Number:	