Your partner in care.
Minnesota CarePartner

Phone: 612.289.5656
Fax: 651.925.0278
www.mncarepartner.com

# Referral Form

Client Name: Gender:

Date of Birth: Social Security Number (insurance verification):

Client Phone Number:

Best time to call? ☐ Morning ☐ Afternoon ☐ Evening Is it safe to leave a message? ☐ YES ☐ NO

Email: Preferred method of communication: ☐ Calls ☐ Text ☐ Email

Current Address:

☐ Client's home ☐ Parent/Guardian home ☐ Foster home ☐ Shelter ☐ Group home ☐ Other:

Who has custody of the client? ☐ Parents ☐ County ☐ Other:

Name of Parent(s)/ Legal Guardian: Phone:

Foster Parent(s) (if applicable): Phone:

If Client is a minor, Who should the provider schedule with?

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Referent's Name: Agency:

Phone Number: Email:

Is there an ROI attached to allow MNCP to update you? ☐ Yes ☐ No

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Primary Insurance: ☐ UCare ☐ Medica ☐ Medicaid ☐ HealthPartners ☐ BlueCross

Commercial Plans: ID #_____ Group#_____

Medicaid Plans: PMI#: _____ Group#_____

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Services Requested (Check all that apply)

- ☐ Diagnostic Assessment
- ☐ Individual ARMHS-Skills
- ☐ CTSS- Skills: Circle one below
  Individual Family
- ☐ Therapy: Circle one below
  Individual Family
- ☐ Play Therapy
- ☐ Adolescent Emotion Regulation Group
- ☐ Ramsey County Community Support Program

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Primary Concerns: Please check all that apply

- ☐ Depression
- ☐ Anxiety
- ☐ Post-Traumatic Stress Disorder
- ☐ Psychosis
- ☐ Autism Spectrum Disorder
- ☐ Aggression
- ☐ Behavioral Concerns: Where?
- ☐ Other:
- ☐ Suicidal Ideation
- ☐ Homicidal Ideation
- ☐ History of Suicide Attempts
- ☐ Self-Injurious Behavior
- ☐ Recent Life Transition
- ☐ Parenting Challenges
- ☐ Anger Management
- ☐ Intimate Partner Violence- Survivor
- ☐ Intimate Partner Violence - Child Witness
- ☐ Intimate Partner Violence - Perpetrator
- ☐ History of Sexual Assault/Abuse
- ☐ Child Abuse- Survivor
- ☐ Child Abuse- Perpetrator
- ☐ Emotional Regulation

Risk of Harm to Self: ☐ Low ☐ Medium ☐ High ☐ Crisis

Risk of Harm to Others: ☐ Low ☐ Medium ☐ High ☐ Crisis

Please explain:

If child protection involvement, please provide harm statement and collateral info.

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Is there violence in the home? ☐ Yes ☐ No

Are there any active OFP's, DANCO's, or HRO's? ☐ Yes ☐ No

If yes, please identify the parties involved:

Please list any precautions that need to be taken below:

Are there pets in the home? ☐ No ☐ Cats ☐ Dogs ☐ Other – Please list :

Do the pets have a history of aggression? ☐ Yes ☐ No

Are there any other safety concerns the provider should be aware of?

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Are there any cultural or language considerations?

Is an interpreter needed? ☐ Yes ☐ No

Client preference for worker (e.g., cultural, gender, language, etc.):

Client Availability:

☐ Mornings ☐ Afternoons ☐ Evenings

☐ Sunday ☐ Monday ☐ Tuesday ☐ Wednesday ☐ Thursday ☐ Friday ☐ Saturday

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Referral Checklist

*Please include all the below information:*

☐ MN CarePartner Referral Form
☐ Release of Information (between Referent and MNCP)
☐ Current DA (if applicable)
☐ Harm statement and collateral info (If involved in Child Protection)

Please send referral and all necessary documentation to:
Fax: 651-925-0278 or
Email: referrals@mncarepartner.com

**Referrals are NOT able to be accepted without current and active insurance or a release of information*