



REFERRAL FORM - ADULT

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?	<input type="checkbox"/> Yes <input type="checkbox"/> No	Which:	Eligible for Indian Health Services?	<input type="checkbox"/> Yes <input type="checkbox"/> No	
Gender Identity:			Preferred Pronouns:		
Sexual Orientation:			Living Situation:		
Address:		City		State	Zip
Phone:		Message ok? <input type="checkbox"/> Yes <input type="checkbox"/> No	Email:		
Preferred Method of Contact:	<input type="checkbox"/> Phone Call	<input type="checkbox"/> Text	<input type="checkbox"/> Email	Best Time to Contact:	
Reason for Referral:					
Primary Concerns:					
Substances Used:					
Currently Receiving Medication Assisted Treatment?	<input type="checkbox"/> Yes <input type="checkbox"/> No	Clinic?:			
Mental Health Diagnoses/Concerns:					
Current Therapy/Treatment Services & Supports					

Funding/Payment Information:

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

You may submit this form to:

email: roots@mncarepartner.com fax: 612.564.5932 web: www.mncarepartner.com/referral