METRO PSYCHOLOGY SUPPORT SERVICES
ADULT REHABILITATIVE MENTAL HEALTH SERVICES

2550 UNIVERSITY AVE. W #163 S.
ST PAUL MN 55114
OFFICE: 651.645.7971 FAX: 855.933.2603

REFERRAL FOR SERVICE

NAME_____ CURRENTLY ENROLLED IN **IRTS** OR **ACT**? YES____NO_____

ADDRESS_____ CITY/ZIP CODE_____

SOCIAL SECURITY_____ DOB_____

HOME PHONE_____ CELL PHONE_____

MEDICAID# (starts with a "0")_____MEDICARE#_____PMAP#_____

INITIAL DIAGNOSIS_____

LEGAL GUARDIAN (NAME): _____ PHONE: _____

Please Note! If the client has had a Diagnostic Assessment in the past **12 months**, please fax it to 855-933-2603. Insurance only covers 1 DA, per year, for the client. Has a DA been done in the past 12 months? YES_____ NO_____

PLEASE INDICATE AREAS THAT APPLY TO CLIENT

FINANCIAL ASSISTANCE	YES NO	
EMPLOYMENT ASSISTANCE	YES NO	
EDUCATIONAL FUNCTIONING	YES NO	
SOCIAL FUNCTIONING	YES NO	
MEDICATION MONITORING/ED.	YES NO	
MEDICAL/DENTAL ASSISTANCE	YES NO	
MENTAL HEALTH NEEDS	YES NO	
SOBRIETY SKILLS	YES NO	
SELF-CARE	YES NO	
HOUSING	YES NO	
TRANSPORTATION SKILLS/ SERVICES	YES NO	
COMMUNITY RESOURCES	YES NO	
ANY SAFETY CONCERNS WE SHOULD BE AWARE OF BEFORE SENDING A PROVIDER TO THE CLIENT'S HOME? IF YES, PLEASE EXPLAIN	YES NO	EXAMPLES: Weapons in the home, aggressive animals, previous history of violence, bed bugs, ect…

REFERRED BY_____ DATE_____

AGENCY_____DIRECT PHONE _____ EMAIL_____