

**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/<br>SERVICES                                                                                           | YES NO |                                                                                                      |
| COMMUNITY RESOURCES                                                                                                          | YES NO |                                                                                                      |
| ANY SAFETY CONCERNS WE<br>SHOULD BE AWARE OF BEFORE<br>SENDING A PROVIDER TO THE<br>CLIENT'S HOME? IF YES,<br>PLEASE EXPLAIN | YES NO | EXAMPLES: Weapons in the home, aggressive animals, previous<br>history of violence, bed bugs, ect... |

REFERRED BY \_\_\_\_\_ DATE \_\_\_\_\_

AGENCY \_\_\_\_\_ DIRECT PHONE \_\_\_\_\_ EMAIL \_\_\_\_\_